



Report on the National Suicide Hotline Improvement Act of 2018

Prepared by the:

**Wireline Competition Bureau
Office of Economics and Analytics**

Submitted to the:

**Senate Committee on Commerce, Science, and Transportation
Senate Committee on Health, Education, Labor and Pensions
Senate Committee on Veterans' Affairs
House of Representatives Committee on Energy and Commerce
House of Representatives Committee on Veterans' Affairs**

August 14, 2019

I. INTRODUCTION

Pursuant to the National Suicide Hotline Improvement Act of 2018 (the Act),¹ this Report recommends that a 3-digit dialing code be used for a national suicide prevention and mental health crisis hotline system. The Act directs the Federal Communications Commission (FCC or Commission), in coordination with the Assistant Secretary of Health and Human Services for Mental Health and Substance Use and the Secretary of Veterans Affairs, to (1) analyze the effectiveness of the existing National Suicide Prevention Lifeline, including how well it is working to address the needs of Veterans, and (2) examine the feasibility of designating a simple, easy-to-remember, 3-digit dialing code to be used for a national suicide prevention and mental health crisis hotline system.² As part of its feasibility analysis, the FCC must (1) consider each of the current N11 dialing codes as well as other simple, easy-to-remember, 3-digit dialing codes;³ (2) consult with the North American Numbering Council (NANC); and (3) review reports provided by the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) and the Department of Veterans Affairs (VA).⁴ The Act further directs the FCC to submit a Report that recommends whether a particular N11 dialing code or other 3-digit dialing code should be used for a national suicide prevention and mental health crisis hotline system.⁵

Based on the record before us, including reports received from the SAMHSA, VA, and NANC, we find that (1) designating a 3-digit code dedicated solely for the purpose of a national suicide prevention and mental health hotline would likely make it easier for Americans in crisis to access potentially life-saving resources; and (2) the Commission should initiate a rulemaking proceeding to consider designating 988 as the 3-digit code to be used for this purpose.

II. BACKGROUND

Congress passed the Act “at a time when the importance of rapid access to crisis intervention and suicide prevention services has never been more critical.”⁶ As SAMHSA explains, in 2017, “more than 47,000 Americans died by suicide and more than 1.4 million adults attempted suicide.”⁷ According to the Centers for Disease Control and Prevention (CDC), from 1999 to 2016, suicide increased in 49 of the 50 states, and in more than half of those states, the increase was greater than 20%.⁸ Moreover, the largest increase in deaths by suicide occurred in the past decade, and from 2016 to 2017, an increase of 3.7% (more than 2,000 additional suicide deaths) was recorded.⁹ Suicide rates are higher across various at-risk populations, including Veterans and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ)

¹ See National Suicide Hotline Improvement Act of 2018, Pub. L. No. 115-233, 132 Stat. 3425 (2018) (Act).

² *Id.* § 3(a)(1)(A)-(B).

³ An N11 dialing code is an abbreviated dialing code that consists of three digits, the first of which may be any digit other than a 1 or 0 and the last two of which is a 1 (*e.g.*, 211 and 911). *Id.* § 2.

⁴ *Id.* § 3(a)(2)(A)(i)-(iii); *see also id.* § 3(b)(1).

⁵ *Id.* § 3(b)(1)-(2).

⁶ The Substance Abuse and Mental Health Services Administration Report to the Federal Communications Commission, WC Docket No. 18-336, CC Docket No. 92-105, at 2 (Feb. 7, 2019) (SAMHSA Report) (attached hereto as Appendix A).

⁷ *Id.* at 2 (internal citations omitted).

⁸ *Id.*

⁹ *Id.*

communities. More than 20 Veterans die by suicide every day¹⁰ and between 2008 and 2016, there were more than 6,000 Veteran suicides each year.¹¹ According to the CDC, LGBTQ youth contemplate suicide at a rate almost three times higher than heterosexual youth,¹² and more than 500,000 LGBTQ youth will attempt suicide this year.¹³

Recognizing the need to ease access to potentially life-saving resources,¹⁴ Congress tasked the FCC with (1) analyzing the effectiveness of the current National Suicide Prevention Lifeline,¹⁵ which is accessible by dialing the 10-digit number, 1-800-273-8255 (TALK); and (2) examining the feasibility of designating a simple, easy-to-remember, 3-digit dialing code to be used for a national suicide prevention and mental health crisis hotline system.¹⁶ The statute requires the FCC to consider existing N11 codes (i.e., 211, 311, 411, 511, 611, 711, 811, and 911) as well as other simple, easy-to-remember, 3-digit dialing codes (non-N11 codes).

To assist the FCC in preparing this Report, the Act requires (1) SAMHSA to provide a report on, among other things, the potential impact of the designation of an N11 code or other 3-digit code for a suicide prevention and mental health crisis hotline system on suicide prevention, crisis services, and other hotlines, including the National Suicide Prevention Lifeline and the Veterans Crisis Line;¹⁷ and (2) the VA to provide a report on “how well the National Suicide Prevention Lifeline . . . is working to address the needs of veterans.”¹⁸ The Act further requires the FCC to consult with the NANC on its feasibility analysis. Below, we discuss the reports provided by SAMHSA and the VA as well as the NANC; each of these reports provided valuable information and analysis to assist us in preparing this Report. We also discuss the public comments we received on the issues that must be addressed pursuant to the Act and on the findings in the NANC Report.¹⁹

A. The National Suicide Prevention Lifeline and the SAMHSA Report

SAMHSA funds the National Suicide Prevention Lifeline (Lifeline), which is a national network of 163 crisis centers linked by a toll-free number, 1-800-273-8255 (TALK),²⁰ and “available to people in

¹⁰ See Letter from Senator Tammy Baldwin and Senator Dan Sullivan, U.S. Senate Commerce Committee, to Hon. Ajit Pai, Chairman, FCC, WC Docket No. 18-336, at 1-2 (dated July 18, 2019) (Sen. Baldwin and Sen. Sullivan July 18, 2019 Letter).

¹¹ U.S. Dept. of Veterans Affairs, Veterans Health Administration, Office of Mental Health and Suicide Prevention, Veteran Suicide Data Report 2005-2016, at 4 (2018), https://www.mentalhealth.va.gov/docs/data-sheets/OMHSP_National_Suicide_Data_Report_2005-2016_508.pdf.

¹² The Trevor Project, Facts About Suicide, <https://www.thetrevorproject.org/resources/preventing-suicide/facts-about-suicide/> (last visited Aug. 12, 2019).

¹³ Sen. Baldwin and Sen. Sullivan July 18, 2019 Letter at 1.

¹⁴ See, e.g., Press Release, Stewart and Hatch Introduce Bill to Improve National Suicide Prevention Hotline (May 3, 2017), <https://stewart.house.gov/media-center/press-releases/stewart-and-hatch-introduce-bill-to-improve-national-suicide-prevention>.

¹⁵ Act § 3(a)(1)(B).

¹⁶ *Id.* § 3(a)(1)(A).

¹⁷ *Id.* § 3(a)(2)(B).

¹⁸ *Id.* § 3(a)(2)(C).

¹⁹ See *Wireline Competition Bureau Invites Comments on Implementation of the National Suicide Hotline Improvement Act of 2018*, Public Notice, 33 FCC Rcd 11129, 11129 (WCB Nov. 8, 2018) (*Act Public Notice*); *Wireline Competition Bureau Invites Comments on NANC Recommendations on Implementing the National Suicide Hotline Improvement Act of 2018*, Public Notice, DA 19-435 (WCB May 17, 2019) (*NANC Report Public Notice*).

²⁰ The Lifeline can also be accessed via multiple toll-free numbers, including 1-800-784-2433 (1-800-SUICIDE), 1-888-784-2433 (1-888-SUICIDE), and 1-877-784-2432 (1-877-SUICIDA). See *U.S. Department of Health and*

suicidal crisis or emotional distress at any time of the day or night.”²¹ Calls to the Lifeline from anywhere in the United States are routed to the closest certified local crisis centers, and “[s]hould the closest center be overwhelmed by call volume, experience a disruption in service, or if the call is from a part of the state not covered by a Lifeline crisis center, the system automatically routes callers to a backup center.”²² Trained Lifeline counselors “assess callers for suicidal risk, provide crisis counseling, crisis intervention, engage emergency services when necessary, and offer referrals to mental health and/or substance use services.”²³ In addition to taking calls, 26 crisis centers answer online chats on a 24/7 basis.²⁴ In 2018, “the Lifeline answered a total of 2,205,487 calls, with an average of 183,790 calls per month,” and the Lifeline responded to 102,640 crisis chats, with an average of 8,553 chats per month.²⁵

In its report, SAMHSA discusses empirical evidence that has “shown good results regarding effectiveness of the Lifeline,” including “reduction of suicidal ideation and hopelessness, improved suicide risk assessment, response to callers at imminent risk, and improving follow up.”²⁶ For instance, “data from 1,507 monitored calls from 1,140 suicidal individuals across 17 Lifeline crisis centers showed that callers were significantly more likely to feel less depressed, less suicidal, less overwhelmed and more hopeful by the end of calls” handled by Lifeline counselors trained in Applied Suicide Intervention Skills Training.²⁷ Additionally, an evaluation of crisis centers’ experience providing follow-up services to 550 Lifeline callers “revealed that 79.6 percent of callers interviewed 6-12 weeks after their crisis call reported that the follow-up calls stopped them from killing themselves (53.8 percent a lot, 25.8 percent a little).”²⁸ These callers “said follow-up gave them hope, made them feel cared about, and helped them connect to further mental health resources” and they “also reported that the initial crisis calls stopped them from killing themselves (76.2 percent a lot, 18.7 percent a little).”²⁹

In its report, SAMHSA concludes that designating an N11 code for a national suicide prevention and mental health crisis hotline “has the potential to play a key role in improving national crisis intervention and suicide prevention efforts[,] if the launch of a new number is accompanied by efforts to develop a more coordinated crisis system with greater capacity and access to sophisticated data and technology systems, and an ongoing commitment to data driven quality improvement.”³⁰ SAMHSA explains that the “arguments in favor of an N11 national number . . . appear to fall in two categories.”³¹ The first “is the assertion that an N11 number would be easier to remember than a 10 digit number, and that this would lead to more people who are in need of help being able to access it.”³² The second “is the

Human Services Substance Abuse and Mental Health Services Administration Petition for the Permanent Reassignment of Three Toll Free Suicide Prevention Hotline Numbers, WC Docket No. 07-271, Order, 27 FCC Rcd 2965 (WCB 2012); *see also* SAMHSA Report at 3.

²¹ SAMHSA Report at 5.

²² *Id.*

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.* at 8; *see also id.* at 6-8.

²⁷ *Id.* at 8.

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.* at 11-12.

³¹ *Id.* at 12.

³² *Id.*

need for what has been called ‘a 911 for the brain.’”³³ That is, “the combination of the N11 number and the message that mental health crises and suicide prevention are of equivalent importance to medical emergencies would, over time, bring needed parity and could result in additional attention and resources to improve typical local psychiatric crisis services throughout the nation.”³⁴ The SAMHSA Report does not address the potential impact of designating a non-N11 three-digit code on suicide prevention and crisis intervention efforts.

B. The Veterans Crisis Line and the Veterans Administration Report

In 2007, SAMHSA and the VA partnered to establish 1-800-273-8255 (TALK) as the access point for the Veterans Crisis Line.³⁵ The Veterans Crisis Line can be reached by pressing option 1; it can also be accessed via text at 838255 and via online chat by visiting www.veteranscrisisline.net.³⁶ The mission of the Veterans Crisis Line is “to provide 24/7, world-class suicide prevention and crisis intervention services to Veterans, Service members, and their family members.”³⁷ The Veterans Crisis Line “is comprised of 3 linked call centers in Canandaigua, New York, Atlanta, Georgia, and Topeka, Kansas” and it collaborates with a network of over 400 Suicide Prevention Coordinators, which are located at VA facilities across the country.³⁸ Following completion of a call to the Veterans Crisis Line, an electronic consult may be submitted to the Suicide Prevention Coordinator located closest to the Veteran, and the Veteran’s local Suicide Prevention Coordinator will respond to this consult within 24 business hours.³⁹ Since its launch in 2007, “the Veterans Crisis Line has answered more than 3.8 million calls,” and since launching chat services in 2009 and text services in 2011, the Veterans Crisis Line has “answered more than 439,000 chats and nearly 108,000 texts.”⁴⁰

In its report, the VA explains that the Veterans Crisis Line “has expanded the ability to respond to Veterans’ needs by increasing the amount of call centers and responders, drastically lowering the amount of calls unable to be answered by the primary system, decreasing the time to respond once received, and decreasing the rate of calls abandoned.”⁴¹ For example, since the expansion of its crisis call centers in 2016, “the [Veterans Crisis Line’s] ability to respond to demand has significantly increased.”⁴² Specifically, “[c]alls are no longer routinely routed to the contracted back-up center due to inability to respond,” and in fact, “the rollover rate went from 39.16% of calls offered in FY 2016 to 0.16% of calls offered in FY 2018.”⁴³ The VA also reports that, for FY 2018, over 95% of callers surveyed “stated that they would call the [Veterans Crisis Line] again for help” if they were in crisis.⁴⁴

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.* at 3.

³⁶ U.S. Dept. of Veterans Affairs, Veterans Health Administration, Report to the Federal Communications Commission, WC Docket No. 18-336, CC Docket No. 92-105 at 4 (Feb. 7, 2019) (VA Report) (attached hereto as Appendix B).

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.* at 3.

⁴² *Id.* at 11.

⁴³ *Id.*

⁴⁴ *Id.* at 9.

C. The North American Numbering Council Report

Pursuant to the Act's directive that the FCC consult with the NANC in conducting its feasibility analysis, the FCC's Wireline Competition Bureau requested that the NANC study three options for designating a 3-digit code to be used for a national suicide prevention and mental health crisis hotline system—expanding an existing N11 code, repurposing an existing N11 code, and using a new non-N11 code.⁴⁵ In response, the NANC first analyzed the advantages and disadvantages of expanding or repurposing each existing N11 code.⁴⁶

To date, the Commission has assigned six of the N11 codes for the following nationwide uses: 211, for community information and referral services; 311, for non-emergency police services; 511, for traveler information services; 711, for the Telecommunications Relay Service; 811, for notice of excavation activities; and 911, for emergencies.⁴⁷ The remaining N11 codes, 411 and 611, have not been permanently assigned by the Commission, but are used for directory assistance and wireline and wireless carrier customer service and repair, respectively.⁴⁸

In its report, the NANC considered expanding the 211 code as a viable option because 211 is already used for crisis calling in some U.S. markets.⁴⁹ It noted that “[a]llowing 211 operators to act as a first line of defense in suicide prevention calls might alleviate the pressure on 911 call takers and allow the caller to obtain assistance for other non-suicide related services in addition to mental health referrals.”⁵⁰ But the NANC also recognized some disadvantages to expansion of the 211 code, such as requiring callers in crisis to navigate an interactive voice response system, and the potential training deficit of individuals answering 211 calls.⁵¹

The NANC also considered repurposing the 511 code; in so doing, the NANC noted that technological advances, such as smartphone applications and in-vehicle navigation systems may be diminishing the need for access to 511 traveler information services,⁵² and that it is not used as heavily as most other N11 codes.⁵³ However, the NANC also recognized that 511 is deployed in approximately

⁴⁵ See Letter from Kris Anne Monteith, Chief, FCC Wireline Competition Bureau, to Travis Kavulla, Chair, North American Numbering Council, WC Docket No. 18-336, CC Docket No. 92-105 (dated Feb. 22, 2019).

⁴⁶ See Report and Recommendation on the Feasibility of Establishing a 3-Digit Dialing Code for a National Suicide Prevention and Mental Health Crisis Hotline from Travis Kavulla, Chair, North American Numbering Council, to Kris Anne Monteith, Chief, FCC Wireline Competition Bureau, WC Docket No. 18-336, CC Docket No. 92-105, at 6-19 (May 10, 2019) (NANC Report) (attached hereto as Appendix C).

⁴⁷ See *The Use of N11 Codes and Other Abbreviated Dialing Arrangements*, CC Docket No. 92-105, First Report and Order and Further Notice of Proposed Rulemaking, 12 FCC Rcd 5572 (1997) (assigned 311 for non-emergency police and other governmental services); *The Use of N11 Codes and Other Abbreviated Dialing Arrangements*, CC Docket No. 92-105, Second Report and Order, 15 FCC Rcd 15188 (2000) (assigned 711 for telephone relay services for the hearing impaired); *The Use of N11 Codes and Other Abbreviated Dialing Arrangements*, CC Docket No. 92-105, Third Report and Order and Order on Reconsideration, 15 FCC Rcd 16753 (2000) (assigned 211 for information and referral services and 511 for traveler information services); *The Use of N11 Codes and Other Abbreviated Dialing Arrangements*, CC Docket No. 92-105, Fourth Report and Order and Third Notice of Proposed Rulemaking, 15 FCC Rcd 17079 (2000) (assigned 911 as the national emergency number); *The Use of N11 Codes and Other Abbreviated Dialing Arrangements*, CC Docket No. 92-105, Sixth Report and Order, 20 FCC Rcd 5539 (2005) (assigned 811 for providing advanced notice of excavation activities to underground facility operators).

⁴⁸ NANC Report at 10, 13.

⁴⁹ *Id.* at 7.

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Id.* at 12.

⁵³ *Id.*

67% of states today, so repurposing it would require extensive customer re-education, and there would also be costs to states and localities to remove or replace roadway signage where 511 is advertised.⁵⁴

Additionally, the NANC evaluated repurposing the 611 code; in so doing, it considered the heavy usage of 611 today and the impact of such usage on repurposing the code for a national suicide prevention and mental health hotline system.⁵⁵ In particular, based on data collected from approximately 34 service providers for a 3-month period (December 1, 2018 to February 28, 2019), the NANC found that more than 74 million calls were made to 611 during that 3-month period.⁵⁶ While this data collection is not representative of the totals for the entire industry, it is informative for understanding the relative volume and estimating a floor for the total volume for each N11 code. Extrapolating these results on an annual basis indicates that at least 297 million calls are made to 611 each year:

Table 1: Usage of Existing N11 Codes (As Reported by Approximately 34 Service Providers)			
N11 Code	Total Calls: Dec. 1, 2018 to Feb. 28, 2019	Estimated Total Annual Calls⁵⁷	Percentage of Total N11 Calls
611	74,163,403	296,653,612	48.81%
911	43,974,408	175,897,632	28.94%
411	17,793,381	71,173,524	11.71%
311	6,405,646	25,622,584	4.22%
211	4,406,436	17,625,744	2.90%
511	3,398,581	13,594,324	2.24%
811	1,383,094	5,532,376	0.91%
711	406,943	1,627,772	0.27%
Total	151,931,892	607,727,568	100.00%

Accordingly, the NANC determined that repurposing 611 could take many years to implement—more than any other N11 code—and would require significant and lengthy re-education efforts.⁵⁸ In addition, the 611 code would need to sit idle for an extended period of time to further educate customers who may continue to call 611 for customer service or repair purposes after such use is discontinued—a step that would be critical to prevent the crisis hotline from receiving high volumes of misdirected calls and delaying crisis calls from being answered.⁵⁹

In its report, the NANC next analyzed the advantages and disadvantages of designating a new non-N11, 3-digit dialing code for purposes of a national suicide prevention and mental health crisis hotline.⁶⁰ In particular, the NANC considered 988 because it is not currently assigned as an area code, and there are fewer corresponding 988 central office code assignments across the United States than some of the other codes the NANC considered, which minimizes the number of switches that would need development work.⁶¹ In examining the advantages of a wholly unique 3-digit code, the NANC noted that

⁵⁴ *Id.*

⁵⁵ *Id.* at 13-14.

⁵⁶ *See id.* at 20.

⁵⁷ Estimates based on total calls made from December 1, 2018 through February 28, 2019 multiplied by four quarters.

⁵⁸ NANC Report at 14.

⁵⁹ *Id.*

⁶⁰ *Id.* at 25-26.

⁶¹ *Id.* at 41.

such a code prevents the need to “age” an existing N11 code, which should reduce the overall implementation timeline.⁶² A new non-N11 3-digit dialing code should also simplify consumer education campaigns and therefore expedite the rollout of the hotline.⁶³

Ultimately, the NANC recommended expanding the 211 code beyond providing community services to include crisis and suicide prevention services,⁶⁴ stating that is technically feasible and would be the most expedient and beneficial in providing easy access to suicide prevention and mental health crisis support services.⁶⁵ However, the NANC also recommended that, if a single-purpose code is preferred, a new 3-digit dialing code—preferably 988—could be deployed for the use of a national suicide prevention and mental health crisis hotline.⁶⁶ The NANC did not recommend repurposing an existing N11 code at this time; however, it noted that if one must be repurposed, the 511 code would be the best option in part because there are many alternatives to obtain traveler information, and the 511 code would be the most expeditiously repurposed with the least impact on users.⁶⁷ Finally, the NANC recommended that the Commission conduct a Notice of Proposed Rulemaking proceeding before adopting any final order designating a 3-digit dialing code.⁶⁸

D. Public Comments on the Act and the NANC Report

In preparation for this Report, the FCC’s Wireline Competition Bureau sought public comment on the issues that must be addressed pursuant to the Act and on the recommendations in the NANC Report.⁶⁹ The Bureau received over 1,600 comments, with overwhelming support for the designation of a 3-digit code for a national suicide prevention and mental health crisis hotline system.⁷⁰ Commenters argue that a 3-digit code will drastically improve access to the appropriate care⁷¹ and “help reduce the

⁶² *Id.* at 26. “Aging” refers to the practice of making a number that has been in use unavailable for reassignment to another end user or customer, or in this case, unavailable for its new purpose, for a specified period of time. *See Alliance for Telecommunications Industry Solutions Act Public Notice* Comments at 3-4 (explaining that “[n]umber assignment practices have historically required that any repurposed or reclaimed number sit unused for some time to avoid system and consumer confusion” and that “repurpos[ing] an existing N11 code” would require “the designated N11 code to sit unused for a period of time” to “provide time for educational efforts to be implemented to ensure that any existing users of that code are informed of its new use”).

⁶³ NANC Report at 26.

⁶⁴ *See* NANC Report at 3, 44; *see also* SAMHSA Report at 16 (explaining that 40 of the 163 Lifeline crisis centers are currently blended 211/crisis centers that provide both information and referral services and crisis response services).

⁶⁵ NANC Report at 3, 7-8, 22, 25, 40, 44-45.

⁶⁶ *Id.* at 3, 25-26, 41-42.

⁶⁷ *Id.* at 3-4, 12-13, 39-40.

⁶⁸ *Id.* at 44.

⁶⁹ *See Act Public Notice; NANC Report Public Notice.*

⁷⁰ *See, e.g., Integral Care of Travis County Act Public Notice* Comments at 1; National Alliance on Mental Illness of Oregon *Act Public Notice* Comments at 1; Lines for Life *Act Public Notice* Comments at 2; *see also, e.g., American Psychiatric Association Act Public Notice* Comments at 1-2 (explaining that a 3-digit dialing code “would improve access to appropriate care and could reduce the prevalence of psychiatric boarding that is plaguing our emergency departments”); American College of Emergency Physicians *Act Public Notice* Comments at 1-2 (same); People Encouraging People, Inc. *Act Public Notice* Comments at 2; Idaho Suicide Prevention Hotline *Act Public Notice* Comments at 1 (supporting “adoption of a 3 digit number to simply, broadly and effectively promote access to crisis mental health and suicide prevention services”).

⁷¹ *See, e.g., American Psychiatric Association Act Public Notice* Comments at 1-2; Idaho Suicide Prevention Hotline *Act Public Notice* Comments at 1.

pervasive stigma associated with mental health challenges.”⁷² The majority of commenters advocate for a code dedicated solely for the purpose of a national suicide prevention and mental health crisis hotline system—rather than a dual or multi-purpose code—to provide callers with rapid access to trained counselors.⁷³

Although there is widespread agreement in the record that the FCC should designate a 3-digit dialing code for this purpose, there is no consensus among commenters on which code should be designated. Commenters generally discuss one or more of the following codes as potential options for a national suicide prevention and mental health crisis hotline system: 211,⁷⁴ 511,⁷⁵ 611,⁷⁶ and 988.⁷⁷

Some commenters further argue for the need for specialized hotline services for higher-risk populations, including LGBTQ youth and Veterans.⁷⁸ Such specialized services could include establishing an interactive voice response system “to a group that has the resources and expertise to best serve [LGBTQ youth]” and “for specialty partners across all at-risk groups to assist SAMHSA in conducting further trainings to increase the ability for existing counselors to best service callers.”⁷⁹

III. DISCUSSION

A. The National Suicide Prevention Lifeline Could Be More Effective With a 3-Digit Dialing Code

The Act requires the FCC, in coordination with SAMHSA and the VA, to analyze the effectiveness of the existing National Suicide Prevention Lifeline, including how well it works to address the needs of Veterans.⁸⁰ Based on the findings in the SAMHSA and VA Reports discussed above, we

⁷² People Encouraging People, Inc. *Act Public Notice* Comments at 2.

⁷³ See, e.g., Oregon Council for Behavioral Health *Act Public Notice* Comments at 2; see also National Alliance on Mental Illness of Oregon *Act Public Notice* Comments at 1; American Psychiatric Association *Act Public Notice* Comments at 1-2.

⁷⁴ See, e.g., 2-1-1 Broward *NANC Report Public Notice* Comments at 1 (supporting the expansion of 211); see also Alliance of Information and Referral Systems *NANC Report Public Notice* Comments at 3-4; 211 Tampa Bay Cares *NANC Report Public Notice* Comments at 2; IMPACT Alcohol and Other Drug Abuse Services, Inc. *Act Public Notice* Comments at 1.

⁷⁵ See, e.g., Carolyn Levitan *NANC Report Public Notice* Comments at 1; see also American Foundation for Suicide Prevention *NANC Report Public Notice* Comments at 3 (supporting 611 or 511); Centerstone *NANC Report Public Notice* Comments at 2 (same).

⁷⁶ Crisis Now *NANC Report Public Notice* Comments at 1; see also National Action Alliance for Suicide Prevention *Act Public Notice* Comments at 1-2; Utah Department of Health Services *NANC Report Public Notice* Comments at 1.

⁷⁷ See, e.g., Clay Smyth *NANC Report Public Notice* Comments at 1; Kimberly Huynh *Act Public Notice* Comments at 1; Didi Hirsch Mental Health Services *NANC Report Public Notice* Comments at 1 (supporting 988 if 611 is not designated).

⁷⁸ See, e.g., The Trevor Project *Act Public Notice* Comments at 2 (advocating “solutions for giving the best quality care to callers of the Lifeline, specifically for the at-risk LGBTQ youth population,” and arguing that such solutions will help the Lifeline “handle increased capacity” and “address[] one of the highest risk populations in the country”); Sen. Baldwin and Sen. Sullivan July 18, 2019 Letter at 2 (“[W]e believe there is further opportunity to provide specialized services to Veterans by making sure they get immediate access to the care they need.”).

⁷⁹ Sen. Baldwin and Sen. Sullivan July 18, 2019 Letter at 2; see also The Trevor Project *Act Public Notice* Comments at 2 (“[W]e recommend the NSPL transfer appropriate calls to The Trevor Project either via immediate transfer from a menu of options or via warm transfer after speaking to an NSPL counselor. Alternatively, The Trevor Project could be contracted to train NSPL counselors so that LGBTQ individuals can receive the specialized care that’s needed in times of crisis.”).

⁸⁰ Act § 3(a)(1)(B).

find that the Lifeline has been effective, including in addressing the needs of Veterans. However, based on the SAMHSA Report as well as comments filed in the record, we also find that the Lifeline could be more effective in preventing suicides and providing crisis intervention if it were accessible via a simple, easy-to-remember, 3-digit dialing code. In particular, we are cognizant of the value presented by such a code, which could better enable callers in crisis to connect expeditiously to the Lifeline and receive immediate help from crisis counselors. For example, as SAMHSA explains, “[i]f a family member experiences severe chest pains in the company of another family member, both the patient and the family member, despite their heightened anxiety, would remember the number 911, while the concern is that many suicidal people or their family members at a similar moment of suicidal crisis might not remember 1-800-273-8255 (TALK).” And as Lines for Life states, “3-digit access” would “make it easier to connect people in need with help” and “deliver timely and effective crisis intervention services to millions of Americans.”⁸¹ Overall, the record supports the use of a dedicated 3-digit dialing code as a way to increase the effectiveness of suicide prevention efforts, ease access to crisis services, and reduce the stigma surrounding suicide and mental health conditions.⁸²

The Act also instructs the FCC to “make other recommendations, as appropriate, for improving the [Lifeline] generally, including “increased public education and awareness” and “improved infrastructure and operations.”⁸³ Given its expertise regarding and experience with the Lifeline, we incorporate by reference SAMHSA’s recommendations on these issues.⁸⁴ Additionally, the need for specialized services for at-risk populations, including LGBTQ youth and Veterans, should be a factor for (1) SAMHSA, the VA, and Congress when considering any improvements to the Lifeline; and (2) the Commission as it considers designating a 3-digit dialing code for a national suicide prevention and mental health crisis hotline system.

B. The Commission Should Consider Designating 988 as the 3-Digit Dialing Code for a National Suicide Prevention and Mental Health Crisis Hotline

In examining the feasibility of designating a 3-digit dialing code for purposes of a national suicide prevention and mental health crisis hotline system, the Act requires us to consider each of the existing N11 codes as well as other simple, easy-to-remember 3-digit dialing codes (non-N11 codes). Based on the record and the NANC Report, we focus our discussion below on 211, 511, 611, and 988, in particular. We conclude that the Commission should initiate a rulemaking proceeding through a Notice of Proposed Rulemaking to consider designating 988 as the 3-digit dialing code for a national suicide prevention and mental health crisis hotline.

⁸¹ Lines for Life, *NANC Public Notice Comments* at 2-3.

⁸² See, e.g., National Council of Behavioral Health *NANC Report Public Notice Comments* at 1 (“An easy-to-remember 3-digit phone number for a national suicide prevention and mental health hotline would increase public access to life saving crisis resources.”); Integral Care of Travis County *Act Public Notice Comments* at 1; National Alliance on Mental Illness of Oregon *Act Public Notice Comments* at 1; Lines for Life *Act Public Notice Comments* at 2 (arguing that “3-digit access” will meet the dramatically growing need for crisis intervention and “[h]elp eliminate the stigma of mental health by normalizing help seeking for mental illness”); The Trevor Project *NANC Report Public Notice Comments* at 3 (“The Trevor Project has supported a solely dedicated N11 or other three digit code as it confirms this is a national issue which deserves the federal government’s attention.”); American Psychiatric Association *Act Public Notice Comments* at 1-2 (explaining that a 3-digit dialing code “would improve access to appropriate care and could reduce the prevalence of psychiatric boarding that is plaguing our emergency departments”); American College of Emergency Physicians *Act Public Notice Comments* at 1-2 (same); People Encouraging People, Inc. *Act Public Notice Comments* at 2 (“A three-digit access line can help reduce the pervasive stigma associated with mental health challenges.”); Idaho Suicide Prevention Hotline *Act Public Notice Comments* at 1 (supporting “adoption of a 3 digit number to simply, broadly and effectively promote access to crisis mental health and suicide prevention services”).

⁸³ Act § 3(b)(2)(E).

⁸⁴ See SAMHSA Report at 18-19.

Use of 211. Based on the record, we conclude that 211 is not appropriate for a nationwide suicide prevention hotline because it could create confusion and additional delays to callers in crisis.⁸⁵ The NANC recommended expanding the use of 211 to include crisis and suicide prevention calling services for a variety of reasons: (1) 211 has been in use for over 20 years, and it is already used for crisis calling in some U.S. markets; (2) relevant training and certification processes already exist for organizations that supply 211 services; (3) 211 is already offered to 94% of the population today, so service providers are well-versed in routing calls to 211; and (4) today’s 211 interactive voice response system capabilities could be expanded to route Veteran calls to the Veterans Crisis Line on a priority basis.⁸⁶ The NANC also noted that although all of the eight N11 codes are currently in use, only two of them share some common purpose with crisis and suicide hotlines—211 and 911.⁸⁷

Although we recognize the numerous community services and resources that 211 offers, we agree with Vibrant Emotional Health, which administers the Lifeline for SAMHSA, that an expansion of 211 would not be the most effective way to support national suicide prevention and crisis contact centers and that a single-purpose, 3-digit dialing code would “provide a platform that can be more easily integrated in society and enhance public awareness about the different functions of each distinct three-digit number.”⁸⁸ The record reflects broad support for either the designation of a new non-N11, 3-digit dialing code or a repurposed N11 code for suicide prevention and mental health,⁸⁹ while only the majority of United Way and blended 211/crisis centers support the NANC’s recommendation to expand 211.⁹⁰ Many commenters express concern that if 211 is expanded or repurposed, current 211 operators would be inadequately trained to staff the hotline, compared to trained Lifeline workers.⁹¹ Commenters also assert that callers to

⁸⁵ See AFSP NANC *Public Notice* Comments at 2 (“[I]ncluding mental health and suicide crisis calls within the collection of services that 211 provides belittles the public health emergency that our country is suffering.”); Centerstone NANC *Public Notice* Comments at 2 (expanding 211 instead of designating a 3-digit hotline would cause user confusion and coordination problems); Crisis Now NANC *Public Notice* Comments at 1 (expanding 211 “would merely exacerbate an already fragmented set of workarounds for mental health crisis”); Equality North Carolina NANC *Public Notice* Comments at 1 (expanding 211 subjects callers in crisis to delayed access to experienced assistance or increased wait times).

⁸⁶ NANC Report at 3, 7.

⁸⁷ *Id.* at 3, 20.

⁸⁸ See Vibrant Emotional Health *Act Public Notice* Comments at 7-8; see also Vibrant Emotional Health NANC *Public Notice* Comments 1, 14 (urging the Commission to designate an N11 code solely to suicide prevention because extending or sharing the use of 211 would create confusion and inefficiencies).

⁸⁹ See TGM Consulting, LLC *Act Public Notice* Comments at 8-9 (suggesting an N11 code as the most technically feasible option); American Association of Suicidology *Act Public Notice* Comments at 1 (advocating for an N11 or non-N11 3-digit dialing code); Alliance for Telecommunications Industry Solutions *Act Public Notice* Comments at 2-3 (generally supporting any new, easily recognizable 3-digit dialing code, not repurposing an N11 code); United Suicide Survivors International *Act Public Notice* Comments at 1-3 (supporting the designation of any 3-digit dialing code and rejecting the expansion of 211); Suicide Awareness Voices of Education NANC *Public Notice* Comments at 1 (supporting a solely dedicated N11 code, not a dual use line).

⁹⁰ See United Way of Westchester & Putnam NANC *Public Notice* Comments at 1; Michigan Assoc. of United Way NANC *Public Notice* Comments at 1; 211 Big Bend NANC *Public Notice* Comments at 1; 211 Palm Beach/Treasure Coast NANC *Public Notice* Comments at 1; 2-1-1 Broward NANC *Public Notice* Comments at 1-2; 211 Nat’l Leadership Group NANC *Public Notice* Comments at 1; 211 Tampa Bay Cares NANC *Public Notice* Comments at 1. *But see* United Way Utah NANC *Public Notice* Comments at 1 (“While we see the value [in] a nationwide N11 (or other three-digit number that is easy to remember and dial), we respectfully submit that 2-1-1 is not the best vehicle for addressing our region’s suicide crisis.”).

⁹¹ The Trevor Project NANC *Public Notice* Comments at 2 (“[E]xpanding the use of the existing 211 line to include mental health services would unfortunately be inefficient and diminish the importance of the issue . . . as 211 currently exists, operators are not properly trained to handle these emergency calls, which may lead to confusion for the operator about the appropriate steps to take and for the caller about who they are actually reaching out to for

a crisis number need direct access to a trained counselor, and should not have to “navigate a complex phone tree.”⁹² Calls forwarded to the Lifeline, or the use of an interactive voice response system, would result in an increase of hold times that could risk callers hanging up rather than following the system prompts.⁹³

SAMHSA further explains that although 40 of the 163 Lifeline crisis centers are already blended 211/crisis centers, “the number 211 is associated with information and referral, which, while valuable, does not communicate that this number is a number that suicidal people or their families can call at any time of the day or night for immediate crisis intervention.”⁹⁴ Moreover, SAMHSA reports that its past experience using one hotline for a dual purpose was unsuccessful with disaster relief efforts because callers were confused as to why they were directed to call a suicide hotline for disaster relief.⁹⁵ We therefore agree with SAMHSA and other commenters who assert that an expanded 211 system would create confusion as to the purpose, reduce the quality, and overburden the current capacity of crisis or community services offered, resulting in increased hold times and delayed crisis intervention.⁹⁶ For these reasons, we do not agree with the NANC’s recommendation to expand 211.⁹⁷

Use of 511. Based on the record, we do not believe that 511 should be designated for a national suicide prevention and mental health crisis hotline. The NANC Report states, “if the 211 code is not expanded and an N11 code must be repurposed, then the NANC recommends repurposing 511 because 511 service is not ubiquitously deployed, has many alternatives to obtain such information, and may be the most expeditiously repurposed with the least impact to users.”⁹⁸ There is also support in the record for designating 511.⁹⁹

help.”); India Hawkins *NANC Public Notice Comments* at 1 (stating that the expansion of 211 “would impact the efficiency and speed of individuals in crisis reaching a properly trained crisis counselor”); Nathan Lichtman *NANC Public Notice Comments* at 1 (explaining that as a counselor at a NSPL center, the “training contains around 120 hours of material, to be able to meet caller’s needs as they are in suicidal crises”).

⁹² See, e.g., Shannon Pullen *NANC Public Notice Comments* at 1.

⁹³ United Way Utah *NANC Public Notice Comments* at 1 (suggesting that with or without an IVR system, which creates a lag time in connecting callers to counselors, expanding 211 “create[s] a time gap that can mean life or death”); Joe Hurlbert *NANC Public Notice Comments* at 7 (dated May 28, 2019) (explaining that IVR systems in an expanded 211 would impair the existing system and subject callers in crisis to a phone tree); Rebecca Taft *NANC Public Notice Comments* at 1 (explaining that callers already get overwhelmed and hang up due to the current amount of telephone prompts and wait times when calling 211); Shannon Pullen *NANC Public Notice Comments* at 1 (“[W]hen people take the brave step of reaching out for help, they need direct access without having to navigate a complex phone tree, wait on hold, be transferred multiple times, or tell their stories more than once.”). See also SAMHSA Report at 16 (stating that calling a crisis number “should result in rapid response and the number should be widely recognized as a crisis number, these are not typically characteristics associated with 211 as a number”).

⁹⁴ SAMHSA Report at 16.

⁹⁵ *Id.* at 17.

⁹⁶ See, e.g., Vibrant Act *Public Notice Comments* at 14; Centerstone Act *Public Notice Comments* at 2; Crisis Now Act *Public Notice Comments* at 1; UW Utah *NANC Public Notice Comments* at 1; see also SAMHSA Report at 16.

⁹⁷ NANC Report at 3.

⁹⁸ *Id.* at 4.

⁹⁹ See, e.g., AFSP *NANC Public Notice Comments* at 3 (supporting the use of 611 or 511, but specifically noting that the NANC recommendation of the “511 code, which could have the least public impact if designated for repurposing, given its limited scope and low call volume could be an effective solution”); Carolyn Levitan *NANC Public Notice Comments* at 1 (“We need our own dedicated line such as 511.”); see also Centerstone *NANC Public Notice Comments* at 2 (“Whether an undesignated N11 number (611) or a designated, low-use N11 number (511), we urge the FCC to assign an N11 dialing code as a dedicated, sole-purpose number to respond to our mental health

We recognize that some commenters strongly favor repurposing an N11 code, such as 511, for a national suicide prevention and mental health crisis hotline. And there are several advantages to repurposing 511, including that traveler use of 511 may be diminished due to the availability of smartphone applications and in-vehicle navigation systems, and that 511 is used less than most of the other N11 codes.¹⁰⁰ However, repurposing 511 poses several challenges. Most importantly, it appears that states and localities use 511 to enable drivers to receive information on road conditions during emergencies and information pertaining to AMBER and other public safety-related alerts.¹⁰¹ For this reason alone, we do not believe that 511 should be repurposed. Moreover, while 511 is used less than other N11 codes, the data provided by the NANC indicate that an estimated 13.6 million calls are made to 511 annually. Accordingly, as with repurposing of any N11 code, current use of 511 would have to be discontinued, the code would have to be aged for an extended period of time based on this usage, and the public would need to be re-educated as to the new use.¹⁰² This process risks creating public confusion and delaying the implementation of a 3-digit dialing code for a national suicide prevention and mental health crisis hotline system. Additionally, repurposing 511 would also require states and localities to remove or replace roadway signage across the country that advertises 511 as a local travel information line, which could also lengthen the timeline for implementation.¹⁰³ For all of these reasons, we do not believe that 511 should be designated for a national suicide prevention and mental health crisis hotline.

Use of 611. We also do not recommend repurposing 611 for a national suicide prevention and mental health crisis hotline system.¹⁰⁴ SAMHSA reports that “[n]umerous participants at SAMHSA’s November 2018 expert stakeholder meeting proposed 611 as the most likely and potentially available N11 number.”¹⁰⁵ Additionally, commenters in the record argue that 611 should be repurposed because 611 has not been designated by the FCC, and it is currently used only for wireline and wireless carrier customer

and suicide public health crises.”); Eleanor K. Letcher, M.Ed, CSW *NANC Public Notice* Comments at 1 (“[W]e advocate for 511 or another 3-digit national telephone number for suicide prevention.”).

¹⁰⁰ NANC Report at 12.

¹⁰¹ See, e.g., Florida Department of Transportation, Florida 511, Emergency Info, <https://fl511.com/emergencyinfo> (last visited Aug. 12, 2019) (“Can I use 511 during an emergency? Yes. FDOT provides 511 to help Floridians get vital roadway information during an emergency: hurricanes, flooding, wildfires, high winds and others.”); (“511 also provides AMBER, Silver and Blue Alerts”); Washington State Department of Transportation, 511 Travel Information, <https://www.wsdot.wa.gov/traffic/511/> (last visited Aug. 12, 2019) (“Use the phone keypad or the hands-free voice recognition option to receive . . . [s]tatewide emergency messages and alerts, including AMBER, Silver and Blue Alerts.”); North Carolina Department of Transportation, Traveler Information Management System – FAQ, <https://tims.ncdot.gov/tims/FAQ.aspx?ClientTimeZone=PST8PDT> (last visited Aug. 12, 2019) (“When an AMBER Alert is activated, highway signs in NC will direct the public to call 511 to obtain all information that is available about the child abduction.”); see also Joe Hurlbert *NANC Public Notice* Comments at 6 (dated May 30, 2019) (arguing that the NANC Report does not account for “the Public Service Roles 511 plays including a growing number of states providing information on Amber (and other) Alerts”).

¹⁰² NANC Report at 12-13.

¹⁰³ *Id.* at 12; see also Joe Hurlbert *NANC Public Notice* Comments at 6 (dated May 30, 2019) (“Education will be difficult in that 511 signage (PSA’s) are scattered at various points highways across most states and it is likely the locations are not documented.”).

¹⁰⁴ Then-Senator Orrin Hatch (R-Utah) and Representative Stewart (R-Utah-02) jointly submitted comments explaining that 611 is “the only undesignated, realistically available N11 number,” and that 411 is more ubiquitous than 611. See Sen. Orrin Hatch & Rep. Stewart *Act Public Notice* Comments at 2. However, the NANC Report and data collection not only finds usage of 611 higher than 411, but the use of 611 poses risks similar to expanding 211—confusing the public as to its intended purpose and creating significant delays with implementation. See NANC Report at 14, 20.

¹⁰⁵ SAMHSA Report at 17.

service and repair.¹⁰⁶ Moreover, some commenters assert that the NANC, which includes carriers, has exaggerated concerns associated with repurposing this code because it is in carriers' best interests to preserve the current use of 611.¹⁰⁷

In considering the feasibility of designating 611, we make clear that our primary concern is not the interests of or burden on carriers that currently use this code. Rather, our focus is on the effectiveness of repurposing a code with such heavy existing usage for a national suicide prevention and mental health crisis hotline. In particular, while 611 has not been officially designated by the FCC, data indicate that this code receives nearly *300 million calls* annually. We are therefore concerned that repurposing an N11 code with such high usage would result in a crisis hotline being inundated with misdirected callers seeking other information, causing confusion and delay, and potentially lost lives if a caller in need cannot speak with a counselor quickly.¹⁰⁸ To avoid these results, repurposing any of the N11 codes would require time to educate the public. Given existing usage—again, an estimated 300 million calls per year—re-educating the public regarding use of 611 in particular for a national suicide prevention and mental health crisis hotline could take a substantial amount of time. One method to avoid confusion, misdirected calls, and provide the shortest possible call handling for suicidal callers once the new use begins is to delay implementation of the selected N11 code for an extended period. During that period, callers to that number would be told that it is no longer in use for the prior purpose. Based on experience with transitioning to new numbers, such as the transition from 800-SUICIDE to 800-273-TALK, the significant call volumes of 611 suggest that it would need to lie fallow for many years longer than one of the less-used N11 codes, such as 511. As the NANC explains, “[r]epurposing 611 could take years to implement, as it would require significant and lengthy re-education and education efforts.”¹⁰⁹ In particular, the “611 code would need to sit idle for an extended period of time, to further educate customers that may still continue to call 611 for customer service or repair purposes.”¹¹⁰ These concerns are not merely theoretical—as the NANC points out, “although SAMHSA has not promoted 1-800-SUICIDE since 2007,” “the call volume associated with 1-800-SUICIDE has experienced little decrease in use since it is no longer marketed as a resource,” and “[t]his raises some concern for the repurposing of any N11 code without significant aging, and the need for substantial public education to cease use of that N11 code.”¹¹¹ For these reasons, we do not recommend designating 611 for a national suicide prevention and mental health crisis hotline system.

¹⁰⁶ See, e.g., Centerstone *NANC Public Notice* Comments at 2 (arguing that “establishing a ubiquitous, recognizable national number (similar to 411 or 911) for mental health and suicide prevention would be a transformative step for our nation’s public health” and urging the FCC to designate “an undesignated N11 number (611) or a designated, low-use N11 number”); Elizabeth Parish *Act Public Notice* Comments (“As a Field Advocate for American Foundation for Suicide Prevention (AFSP), I urge the FCC to support the implementation of an N11 dialing code for a suicide prevention crisis hotline system. I strongly encourage the FCC to consider utilizing ‘611’ as the new dialing code. Though select telecom providers use this number for repair and sale services, ‘611’ is the most realistic N11 number available.”); AFSP *NANC Public Notice* Comments at 3 (“AFSP understands that any inconvenience service providers would face for having overused the 611 dialing code would pale in significance compared to the potential lives saved and services provided for such a crucially necessary national purpose as saving lives from emotional and suicidal distress.”).

¹⁰⁷ See, e.g., Joe Hurlbert *NANC Public Notice* Comments at 1-2 (dated June 7, 2019) (arguing that the NANC Report exaggerates issues with repurposing 611 because the majority of NANC members are telecom providers, and it is in their best interest to preserve 611 in its current use as a marketing tool).

¹⁰⁸ NANC Report at 14.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.* at 25.

Use of other N11 codes. We further conclude that none of the other N11 codes should be designated for a national suicide prevention and mental health crisis hotline. For example, repurposing 311 would require a determination as to “where the non-emergency and other government services currently served by the 311 code would need to be assigned.”¹¹² As the NANC points out, “[a]s of 2015, more than 200 cities around the U.S. have traditional 311 services, and another 220 cities, mostly smaller municipalities, use an application to provide some type of 311-style capability.”¹¹³ With respect to 411, “the popular use that exists today to access Directory Assistance Services would be difficult to change from what has become a cultural understanding of the use of 411.”¹¹⁴ Additionally, because 711 is currently used by persons with hearing or speech disabilities to make or receive telephone calls, we do not believe that it should be repurposed.¹¹⁵ Further, the 811 code is the nationwide code for coordinating location services for underground public utilities (*i.e.*, “call before you dig”) in response to the Pipeline Safety Improvement Act of 2002.¹¹⁶ Repurposing it would require legislative changes¹¹⁷ and, more importantly, could have significant implications for pipeline safety.¹¹⁸

We also make clear that we do not recommend expanding or repurposing 911 to serve as a nationwide suicide hotline. Although 911 is recognized as the gold standard for emergency response in the United States, SAMHSA and the NANC noted significant disadvantages to attempting to use 911 as a crisis hotline.¹¹⁹ For example, calls to 911 average 2 minutes or less,¹²⁰ and 911 call-takers focus on identifying the nature of the emergency and the caller’s location to enable prompt dispatch of appropriate emergency response. Thus, the 911 system is not well-suited to provide suicide prevention counseling or to respond to calls that can be handled through conversation with a trained mental health professional rather than dispatching first responders.¹²¹ In addition, the suicide call-volume projections from SAMHSA¹²² and the VA¹²³ indicate that directing these calls to 911 would increase call volumes above levels that the 911 system can reasonably be expected to accommodate.¹²⁴ In light of these disadvantages, we conclude that 911 should not be expanded or repurposed.¹²⁵

¹¹² *Id.* at 10.

¹¹³ *Id.* at n.24.

¹¹⁴ *Id.* at 11.

¹¹⁵ *Id.* at 15.

¹¹⁶ See *Use of N11 Codes and Other Abbreviated Dialing Arrangements*, CC Docket No. 92-105, Sixth Report and Order, 20 FCC Rcd 5539 (2005); see also Pipeline Safety Improvement Act of 2002, Pub. L. No. 107-355, § 17, 116 Stat. 2985, 3008 (2002); NANC Report at 16.

¹¹⁷ NANC Report at 17.

¹¹⁸ See, e.g., U.S. Department of Transportation, Pipeline and Hazardous Materials Safety Administration, 811 Day, <https://www.phmsa.dot.gov/safety-awareness/811-day> (last visited Aug. 12, 2019) (“Calling 811 or visiting www.call811.com, has proven to be the foremost preventive measure in excavation safety and damage prevention. Research has revealed that if someone calls 8-1-1 before they dig, they have a 99 percent chance of avoiding an incident, injury, harm to the environment and even death.”).

¹¹⁹ SAMHSA Report at 16; NANC Report at 17.

¹²⁰ NANC Report at 17.

¹²¹ SAMHSA Report at 16.

¹²² NANC Report, Appendix D, April 2, 2019 SAMHSA Response to NANC Numbering Administration Oversight Working Group (NAOWG) N11 Inquiry.

¹²³ NANC Report, Appendix C, March 19, 2019 Veterans Crisis Line Response to NAOWG N11 Inquiry.

¹²⁴ NANC Report at 21.

¹²⁵ *Id.* at 19; SAMHSA Report at 16.

Use of 988. Having examined the feasibility of existing N11 codes, we now examine use of a non-N11 3-digit code for a national suicide prevention and mental health crisis hotline system. We agree with the NANC’s recommendation of 988 for such a code.¹²⁶ As the NANC explains, a non-N11 3-digit code has several advantages, including (1) “[u]se of a wholly unique 3-digit code prevents the need to age an existing N11 code prior to repurposing,” which “should reduce the overall implementation timeline”; and (2) “[c]onsumer education campaigns would be simplified compared to the repurposing or expanded use of an existing N11 code,” as such campaigns “would be exclusively focused on the new suicide prevention and mental health crisis hotline,” thereby expediting rollout of the hotline.¹²⁷

Moreover, 988 has technical advantages. First of all, it is not currently assigned as a geographic area code¹²⁸ and therefore does not suffer the same problems surrounding repurposing an existing area code. In addition, in order for a switch to detect a new, non-N11 three-digit code, it helps if the code is not comprised of the leading digits (often called the “prefix”) of a local number. In this regard, 988 has fewer corresponding central office code assignments across the U.S. than some other codes the NANC considered.

To be sure, the NANC cautioned in its report that “the 988 code is not without technical and operational concerns.”¹²⁹ Specifically, the NANC explained that currently, it is unlikely that any non-N11 3-digit dialing code, such as 988, can be deployed ubiquitously across all networks.¹³⁰ This is because “[s]ome wireline switches may be unable to support any new 3-digit dialing code that is not an N11 code.”¹³¹ For switches that can support 988, the NANC found that configuration and software upgrades could be implemented fairly quickly.¹³² We recognize that suicide does not discriminate by geographic region, and to be effective, any code designated for a national suicide prevention and mental health crisis hotline system must be ubiquitously deployed.¹³³ From the NANC analysis, however, it seems that the current technical and operational concerns related to the 988 code could be more easily and quickly addressed and resolved than any re-education efforts related to repurposing a N11 code.¹³⁴ Although we believe 988 is the fastest path to implementing a 3-digit code, Commission staff estimates that a relatively small percentage of legacy switches cannot accommodate the 988 code.¹³⁵ As telephone companies continue to upgrade their legacy networks, we expect these legacy switches will be replaced, ultimately making the use of 988 as a designated suicide prevention and mental health crisis hotline ubiquitous.

¹²⁶ NANC Report at 41.

¹²⁷ *Id.* at 26.

¹²⁸ See NANC Report, Appendix B (showing that the North American Numbering Plan Administrator (NANPA) recommended to the NANC “the assignment of an Easily Recognizable NPA Code,” which “due to the unique digit pattern (N22, N33 . . . N88), have been used as non-geographic codes, and have been used to identify services rather than geographic areas”).

¹²⁹ NANC Report at 41.

¹³⁰ *Id.* at 3.

¹³¹ *Id.* at 26.

¹³² *Id.* at 42.

¹³³ See, e.g., AFSP NANC Public Notice Comments at 3 (“Suicide does not discriminate, access across the United States must be uniform and total.”).

¹³⁴ NANC Report at 43 (estimating that implementation time would likely be quicker for most carriers for 988 than repurposing an N11 code).

¹³⁵ The FCC staff estimate is based on a review of switches listed in the iconectiv Local Exchange Routing Guide (LERG) and switch types that cannot support any non-N11 3-digit dialing (i.e., NXX), as identified by the NANC. See NANC Report at 26, n.88.

C. Cost-Benefit Analysis of Designating 988

The Act instructs the FCC to include in this Report an estimate of the costs associated with designating the recommended 3-digit dialing code, including “the costs incurred by service providers” for “translation changes in the network” and “cell site analysis and reprogramming by wireless carriers,” as well as “the costs incurred by States and localities.”¹³⁶ The Act further instructs us to “provide a cost-benefit analysis comparing the recommended dialing code with the [Lifeline].”¹³⁷ The record in this proceeding regarding 988 does not provide extensive information about the costs of implementing 988 to both service providers and States and localities. While we cannot precisely measure the costs and benefits of designating 988 relative to the existing Lifeline, based on the information available, the cost-benefit analysis below demonstrates that the benefits of adopting 988 for purposes of a national suicide prevention and mental health crisis are likely to outweigh the costs. We expect the rulemaking that we recommend the Commission conduct will seek additional data.

Implementing a 3-digit dialing code, such as 988, imposes several types of costs. First, disrupting established dialing and switching routines is likely to cause some misdials, network rerouting, technical glitches, and other disruption costs.¹³⁸ Second, according to the NANC, implementing the necessary switching translation updates would cost service providers an estimated \$92.5 million.¹³⁹ Third, a relatively low percentage of legacy switches will need to be replaced with modern equipment in order to accommodate the 988 code. We estimate that the cost of installing these switches and making them operational will be less than \$300 million.¹⁴⁰ Fourth, educating the public about the new code through a national, multimedia awareness campaign would cost an estimated \$125 million annually for two years, based on recent precedent.¹⁴¹ Finally, federal,¹⁴² state, and local governments, as well as non-government organizations, would have to pay to upgrade or expand crisis centers to handle the increased call volume. SAMHSA estimates that a high performing crisis center spends approximately \$25 per call and an additional 2 million calls (for context, a 100% increase over current call volumes to the Lifeline) would require \$50 million in additional annual funding to provide appropriate capacity to manage anticipated call volumes.¹⁴³

We therefore estimate that total costs for the first year would be approximately \$570 million and total costs for the second year would be approximately \$175 million. This total includes \$50 million in annual expenditures on increased call-center capacity and \$125 million for each of the first two years for a public awareness campaign (\$175 million annually in total). Adding one-time service-provider outlays (\$92.5 million for switching translation updates) brings the total first year costs to \$267.5 million (i.e.,

¹³⁶ Act § 3(b)(2)(B).

¹³⁷ Act § 3(b)(2)(D).

¹³⁸ This is difficult to estimate given the limited data available to us; therefore, we are unable to assign a dollar value.

¹³⁹ The NANC notes implementation costs to service providers “are likely comparable to those that would be incurred if an N11 code is repurposed.” NANC Report at 36, 45.

¹⁴⁰ See *supra* note 135.

¹⁴¹ While the NANC Report (at 29) acknowledges that an extensive public awareness campaign is necessary, it does not furnish cost estimates. A recent example of the sort of national, multimedia, public education campaign needed is the FDA’s “The Real Cost” smoking cessation campaign, which cost \$250 million in its first two years. See <https://www.fda.gov/tobacco-products/public-health-education-campaigns/real-cost-campaign>.

¹⁴² H.R. Rep. No. 116-62, at 116-20 (2019) (recommending an increase of SAMHSA’s funding to \$20 million, an increase of \$8 million, for the Lifeline); see also Labor, Health and Human Services, Education, Defense, State, Foreign Operations, and Energy and Water Development Appropriations Act, 2020, H.R. 2740, 116th Cong. (2019) (as passed by the House on June 19, 2019).

¹⁴³ SAMHSA Report at 20.

\$50 million + \$125 million + \$92.5 million). One-time costs to replace switches are estimated to be less than \$300 million. We add the switching costs to the total (\$267.5 million + \$300 million = \$567.5 million) and round up to arrive at our estimate of \$570 million for the first year. And as stated above, second year costs are estimated to be \$175 million. We expect that costs in subsequent years would be approximately \$50 million annually.

Based on the estimated costs, the benefits of 3-digit dialing would have to exceed \$570 million in the first year and \$175 million in the second year for the benefits to outweigh the costs. In subsequent years, benefits would have to exceed \$50 million annually. We estimate the primary benefit of 3-digit dialing to be a reduction in suicide risk. While the value of a human life cannot be reduced to a dollar figure, we nonetheless require some method of valuing the reduction in mortality risk to show that undertaking this recommendation is reasonable, given its costs. We therefore employ the Department of Transportation's Value of a Statistical Life (VSL), which estimates the value that people put on their own safety. The VSL is currently \$9.6 million—meaning that people, on average, highly value their lives and are willing to spend, for instance, one percent of this amount to reduce their mortality risk by one percent.¹⁴⁴ In order to estimate a benefit floor, above which we expect the benefits exceed the costs, we divide the \$570 million in cost reduction needed for the first year by the \$9.6 million value for a statistical life for a total of nearly 60 statistical lives ($\$570 \text{ million} / \$9.6 \text{ million} = 59.4$). We conclude that if suicide risk could be reduced by 60 statistical lives, the benefits would exceed the costs. This constitutes a 0.13% decrease in suicide mortality risk of the over 47,000 lives lost to suicide in 2017¹⁴⁵ as a benchmark ($60 / 47,000 = 0.00128$). Following the same methodology, if the suicide risk in the second year decreases from 2017 levels by 0.04%, saving 19 lives, the costs would outweigh the benefits.¹⁴⁶ In subsequent years, when annual costs drop to approximately \$50 million, the necessary reduction would be even smaller.

Based on our consultation with the SAMHSA and the VA, we expect that the life-saving benefits of a simple, easy-to-remember 3-digit dialing code such as 988 will exceed the costs of implementation. Crisis call centers save lives. The most recent SAMHSA-funded study found that for callers at imminent risk of committing suicide, counselors sent emergency responders with the caller's cooperation in 19% of the cases; in another 55% of cases, counselors were able to help callers avoid suicide without police or ambulance services.¹⁴⁷ Moreover, empirical studies of suicidal callers have found reductions as large as 25% in callers wanting to self-harm after speaking with hotline counselors.¹⁴⁸ Increasing the convenience and immediacy of access to a national suicide prevention and mental health crisis hotline via a 3-digit dialing code will therefore help spread a proven, effective intervention. In short, we believe that designating the 988 code for a national suicide prevention and mental health crisis hotline system is highly likely to lower suicide mortality risk in the United States by more than 0.13% in the first year and 0.04% in the second year, and thus that the benefits of this action are quite likely to outweigh the costs.

¹⁴⁴ The FCC last used the Department of Transportation's \$9.6 million VSL to value mortality risk reductions in *Wireless Emergency Alerts Amendments to Part 11 of the Commission Rules Regarding the Emergency Alert System*, Second Report and Order and Second Order on Reconsideration, 33 FCC Rcd 1320, 1346 (2018).

¹⁴⁵ See SAMHSA Report at 2.

¹⁴⁶ We estimate year 2 costs to be \$175 million. Dividing \$175 million by \$9.6 million implies the 988 code would have to save nearly 19 lives for costs to exceed benefits ($\$175 \text{ million} / \$9.6 \text{ million} = 18.2$). Dividing 19 lives saved by the 47,000 lives lost to suicide in 2017 suggests that a 0.04% reduction is required for the benefits to exceed the costs ($19 / 47,000 = 0.0004$).

¹⁴⁷ SAMHSA Report at 7.

¹⁴⁸ Philip Tyson *et al.*, *Preventing Suicide and Self-Harm: Evaluating the Efficacy of a Helpline From a Service User and Helpline Worker Perspective*, *Crisis* (Sept. 2016), 37(5): 355.

IV. RECOMMENDATION

We recommend that the Federal Communications Commission initiate a rulemaking to designate a 3-digit dialing code for a national suicide prevention and mental health crisis hotline system, and that the Commission consider designating 988 as the dialing code for this important purpose.

APPENDIX A
THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
(SAMHSA) REPORT

National Suicide Hotline Improvement
Act:
The Substance Abuse and Mental Health
Services Administration Report to the
Federal Communication Commission

February 7, 2019

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Suicide Prevention Branch

SAMHSA
Substance Abuse and Mental Health
Services Administration

Table of Contents

Executive Summary	1
Context and Background of Legislation	2
National Suicide Prevention Lifeline History, Development, and Structure.....	3
National Suicide Prevention Lifeline Effectiveness	6
National Suicide Prevention Lifeline Challenges: The Need for Growth in Community Crisis Center Capacity to Meet Growing Volume.....	8
Potential Impact of an N11 Number on National Suicide Prevention and Crisis Intervention Efforts.....	11
Potential Impact of a New N11 Number on the National Suicide Prevention Lifeline	14
911, 211, and 611 Significance for the National Suicide Prevention Lifeline	15
Recommendations for Improving the Lifeline.....	18
References.....	21
Appendix 1: National Suicide Prevention Lifeline In-State Answer Rate.....	24
Appendix 2: 21 st Century Cures Act – Section 9005: National Suicide Prevention Lifeline Program.....	26
Appendix 3: National Suicide Hotline Improvement Act Expert Stakeholder Meeting Participant List	27

Executive Summary

On August 14, 2018, President Trump signed into law the National Suicide Hotline Improvement Act (hereafter referred to as “the Act”).¹ The Act states:

“(B) SAMHSA STUDY AND REPORT TO ASSIST COMMISSION. – To assist the Commission in conducting the study under paragraph (1), the Assistant Secretary for Mental Health and Substance Use shall analyze and, not later than 180 days after the date of enactment of this Act, report to the Commission on – (i) the potential impact of the designation of an N11 dialing code, or other covered dialing code, for a suicide prevention and mental health crisis hotline system on – (I) suicide prevention; (II) crisis services; and (III) other suicide prevention and mental health crisis hotlines, including – (aa) the National Suicide Prevention Lifeline; and (bb) the Veterans Crisis Line; and (ii) possible recommendations for improving the National Suicide Prevention Lifeline generally, which may include – (I) increased public education and awareness; and (II) improved infrastructure and operations.”

The Act gives SAMHSA 6 months to prepare this report, which is due to the Federal Communications Commission (FCC) on February 14, 2019.

This report reviews the current context for the Act; the history and structure of the National Suicide Prevention Lifeline (hereafter referred to as “the Lifeline”), as well as its relationship to the Veterans Crisis Line; the patterns of increasing call volume for the Lifeline; and the challenges in assuring adequate capacity to answer calls. This report also reviews evaluations of the effectiveness of the Lifeline, estimates the potential impact of a new N11 number on national suicide prevention and crisis intervention efforts, as well as the impact on the Lifeline specifically, and reviews potential improvements to the Lifeline. Finally, this report provides concluding recommendations describing how an N11 national suicide prevention and crisis intervention number could play an instrumental role in improving suicide prevention and crisis intervention nationally.

¹ “National Suicide Hotline Improvement Act” (PL115-233, 14 August 2018), <https://www.congress.gov/bill/115th-congress/house-bill/2345>.

Context and Background of Legislation

In 2017 more than 47,000 Americans died by suicide (Murphy, Xu, Kochanek, Arias, 2018) and more than 1.4 million adults attempted suicide (SAMHSA's National Survey on Drug Use and Health, 2018). According to the Centers for Disease Control and Prevention (CDC), from 1999 to 2016 suicide has increased in 49 of the 50 states and in more than half of those states the increase is greater than 30 percent (Stone, Simon, Fowler, 2018). The largest increase in deaths by suicide occurred in the past decade and from 2016 to 2017 an increase of 3.7 percent (more than 2000 additional suicide deaths) was recorded (Hedegaard, Curtin, Warner, 2018). It was within this context, at a time when the importance of rapid access to crisis intervention and suicide prevention services has never been more critical, that Congress passed and the President signed into law the National Suicide Hotline Improvement Act (hereafter referred to as "the Act"). The Act, signed into law on August 14, 2018, states:

“(B) SAMHSA STUDY AND REPORT TO ASSIST COMMISSION. – To assist the Commission in conducting the study under paragraph (1), the Assistant Secretary for Mental Health and Substance Use shall analyze and, not later than 180 days after the date of enactment of this Act, report to the Commission on – (i) the potential impact of the designation of an N11 dialing code, or other covered dialing code, for a suicide prevention and mental health crisis hotline system on – (I) suicide prevention; (II) crisis services; and (III) other suicide prevention and mental health crisis hotlines, including – (aa) the National Suicide Prevention Lifeline; and (bb) the Veterans Crisis Line; and (ii) possible recommendations for improving the National Suicide Prevention Lifeline generally, which may include – (I) increased public education and awareness; and (II) improved infrastructure and operations.”

The passage of the Act also occurs within the context of the passage of the 21st Century Cures Act in December 2016 (hereafter referred to as “the Cures Act”),² which has significant implications for mental health care in America, and for national suicide prevention and crisis intervention efforts in particular. For example, the Cures Act authorized the National Suicide Prevention Lifeline (hereafter referred to as “the Lifeline”) in law for the first time,³ authorized an adult suicide prevention program, reauthorized youth suicide efforts through the Garrett Lee

² “21st Century Cures Act” (Public Law 114-255, 13 December 2016),

<https://www.congress.gov/114/bills/hr34/BILLS-114hr34enr.xml>

³ “21st Century Cures Act” (Public Law 114-255, 13 December 2016), Section 9005.

Smith Memorial Act, and authorized a grant program to support community crisis response systems.

National Suicide Prevention Lifeline History, Development, and Structure

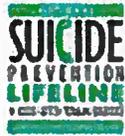
Congress first appropriated funding for the networking and certification of suicide prevention hotlines using a single toll free number in 2001. SAMHSA awarded a grant to the American Association of Suicidology and the Kristin Brooks Hope Center (KBHC) utilizing the number 1-800-SUICIDE and establishing a network of crisis centers willing to answer these calls. In 2004, SAMHSA re-competed the grant and the award was made to the Mental Health Association of New York City. In 2005, they launched the Lifeline utilizing the number 1-800-273-8255 (TALK). The Kristen Brooks Hope Center decided to continue to manage calls to 1-800-SUICIDE without federal support.

In 2006, a Spanish language sub-network was created in the Lifeline network and currently is the “press 2” option in the recorded greeting.

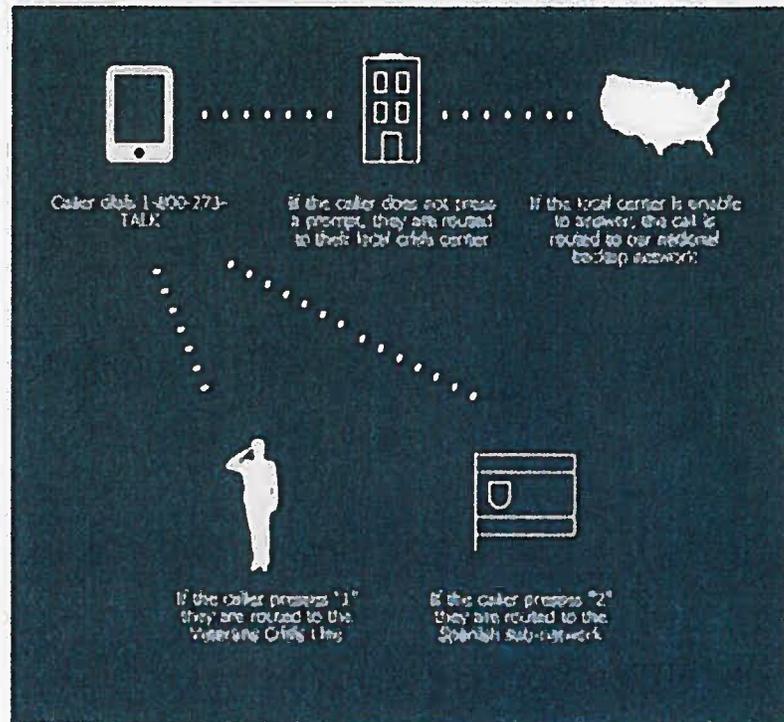
In January 2007, faced with the imminent likelihood of the collapse of the 1-800-SUICIDE number, and at the request of SAMHSA, the FCC temporarily assigned the number 1-800-SUICIDE to SAMHSA. In February 2012, KBHC and SAMHSA filed a joint petition with the FCC requesting that 1-800-SUICIDE be permanently assigned to SAMHSA, which was granted by the FCC in March 2012. Calls coming into 1-800-SUICIDE were routed and answered in the same way as calls to 1-800-273-8255 (TALK).

In 2007, SAMHSA and the U.S. Department of Veterans Affairs (VA) partnered to establish 800-273-8255 (TALK) as the access point for the Veterans Crisis Line (VCL). Callers that dialed 1-800-273-8255 (TALK) hear a recorded announcement and if they press “1” are connected to the VCL. Following recommendations by the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, the VCL was cobranded as the Military Crisis Line within the Department of Defense to answer calls by service members and their families, as well as National Guard, and Reservists. Calls to the VCL are answered by professional VA responders in Canandaigua, New York, Atlanta, Georgia, and Topeka, Kansas. In 2008, approximately 29 percent of Lifeline callers pressed “1”.

Figure 1. National Suicide Prevention Lifeline's Call Flow



The Lifeline's Call Flow



The connection of the VCL to the Lifeline is a central component of the Inter-Agency Agreement between SAMHSA and VA to assure federal collaboration in Lifeline meeting the needs of the nation's veterans and service members. The Cures Act now requires that the VCL is made available through the Lifeline to veterans, service members, and their families. SAMHSA and VA communicate regularly to monitor the implementation of the Lifeline press "1" option, as well as the experience of veterans who call the Lifeline but do not press "1".

In 2011, given the increasing demand for online crisis services, SAMHSA began providing supplemental funds to the Lifeline to build the capacity of network centers to provide chat crisis intervention services, initially for a period of 4 hours a day, 5 days a week. Due to the strong demand for this service, the Lifeline expanded the chat service, which is accessed through the Lifeline website at www.suicidepreventionlifeline.org to 12 hours a day in 2013. Currently, the

26 crisis centers that answer Lifeline crisis chats are available 24 hours a day, seven days a week, and 365 days a year.

The Lifeline is currently a network of 163 crisis centers linked by a toll-free telephone number, 1-800-273-8255 (TALK), and available to people in suicidal crisis or emotional distress at any time of the day or night. Callers to 1-800-SUICIDE also continue to be answered through the Lifeline system. The service routes calls from anywhere in the United States to the closest certified local crisis centers, spanning every state but Wyoming. Should the closest center be overwhelmed by call volume, experience a disruption in service, or if the call is from a part of the state not covered by a Lifeline crisis center, the system automatically routes callers to a backup center.⁴ Trained counselors assess callers for suicidal risk, provide crisis counseling, crisis intervention, engage emergency services when necessary, and offer referrals to mental health and/or substance use services.

In 2018, the Lifeline answered a total of 2,205,487 calls, with an average of 183,790 calls per month. Also in 2018, 102,640 crisis chats were responded to, with an average of 8,553 chats per month.

The Lifeline has become the nation's mental health and suicide prevention safety net. In many communities the only immediately available resource for a suicidal person would be an emergency room or the Lifeline and its network of crisis centers. All network crisis centers have adopted protocols and policies that represent best practices in the field, including "Standards for Suicide Risk Assessment,"⁵ and "Guidelines for Helping Callers at Imminent Risk for Suicide."⁶ The Lifeline has also supported the training of crisis center staff in Applied Suicide Intervention Skills Training (ASIST), an internationally disseminated gatekeeper training program (ASIST; LivingWorks, 2010). In addition, the Lifeline has promoted follow up of suicidal callers as a best practice and many crisis centers have incorporated telephonic follow up into their work. This practice has been shown to be effective in reducing suicidal behavior in research supported

⁴ Calls from Wyoming go directly to a backup center.

⁵ National Suicide Prevention Lifeline Risk Assessment Standards (2007). Retrieved from <https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Suicide-Risk-Assessment-Standards-1.pdf>

⁶ National Suicide Prevention Lifeline Imminent Risk Policy (2012). Retrieved from <https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Lifeline-Policy-for-Helping-Callers-at-Imminent-Risk-of-Suicide.pdf>

by the National Institute of Mental Health and the Department of Veterans Affairs (Miller, et. al., 2017 and Stanley, Brown et. al., 2018).

National Suicide Prevention Lifeline Effectiveness

Empirical evidence to support the effectiveness of Lifeline crisis centers for suicide prevention has steadily grown (Gould, Cross, Pisani, Munfakh, & Kleinman, 2013; Gould & Kalafat, 2009; Gould, Kalafat, Munfakh, & Kleinman, 2007; Gould et al., 2018; Gould et al., 2016; Gould, Munfakh, Kleinman, & Lake, 2012). The Lifeline has systematically utilized these findings to promote improvement throughout the Lifeline network. The Lifeline is increasingly recognized as a critical and effective component of the mental health and suicide crisis response care system in the United States and has been recognized as a model program and key national resource helping to advance knowledge and move suicide prevention efforts forward (U.S. Department of Health and Human Services, 2012, pp. 54, 57, 99).

The evaluation of the national network of certified crisis call centers has been ongoing since the network's inception in 2001, and has become a gold standard in data-driven decision-making. The initial evaluations of SAMHSA's earliest hotline initiatives examined proximal outcomes of crisis centers' effectiveness as measured by changes in callers' crisis and suicide states from the beginning to the end of their calls and intermediate outcomes within three weeks of their calls. Data collected from 2002 to 2004 from nearly 3,000 callers from eight crisis centers demonstrated that seriously suicidal individuals were calling telephone crisis services (e.g., 8 percent in midst of attempt, 58 percent had made prior attempt); and that significant reductions in callers' self-reported crisis and suicide states occurred from the beginning to the end of the calls. Specifically, there were significant decreases in callers' reports of intent to die, hopelessness, and psychological pain over the course of the call (Kalafat, Gould, Munfakh, & Kleinman, 2007; Gould, Kalafat, Munfakh & Kleinman, 2007).

While providing support for the clinical effectiveness of the network of crisis centers, early evaluation results also raised a concern about the adequacy of suicide risk assessments conducted by some crisis center staff (Mishara et al., 2007a; 2007b; Kalafat et al., 2007). In response, SAMHSA and the Lifeline focused on standardizing crisis counselor practices and training across the network (Joiner et al., 2007), including disseminating ASIST. An evaluation of the impact of ASIST's implementation demonstrated improvements in caller's outcomes. For

example, data from 1,507 monitored calls from 1,410 suicidal individuals across 17 Lifeline crisis centers showed that callers were significantly more likely to feel less depressed, less suicidal, less overwhelmed, and more hopeful by the end of calls handled by ASIST-trained counselors (Gould, Cross, Pisani, Munfakh, & Kleinman, 2013). Additionally, a study of California suicide prevention hotlines found that California hotlines affiliated with the Lifeline, which asks crisis centers to adhere to its Standards for Suicide Risk Assessment, were significantly more likely to assess for the presence of suicidal ideation and behavior than centers not affiliated with the Lifeline (Ramchand, et.al, 2017).

The concept of imminent suicide risk is critical to and used regularly by suicide crisis counselors, as well as emergency department staff, and other first responders. The need for a clear and explicit policy for such high-risk callers to the Lifeline was highlighted by the series of SAMHSA-funded evaluations of network crisis centers published in 2007 (Gould et al., 2007; Mishara et al., 2007a; Mishara et al., 2007b). Gould and colleagues (2007) found that for callers who had taken some action to kill themselves immediately before calling the crisis center, emergency rescue was initiated in only 37.9 percent of cases. On monitored calls where a suicide attempt was in progress, Mishara et al (2007) found that emergency services were known to be dispatched in 18.2 percent of cases (6/33), and the caller changed his/her mind about the attempt in 24.2 percent (8/33), leaving 57.6 percent of calls (19/33) apparently without a satisfactory resolution. In January 2008, the Lifeline disseminated guidelines and policies for helping callers at imminent risk of suicide, to which the crisis centers across the network have been asked to conform. Following the dissemination of the Lifeline Imminent Risk policy, an evaluation of the assessment and management of imminent risk callers to the Lifeline employed data from 491 call reports completed by 132 counselors at eight crisis centers (Gould et al., 2016). Findings demonstrated that crisis counselors actively obtained the collaboration of the vast majority (over 75 percent) of callers they identified as being at imminent risk, consistent with the Lifeline Imminent Risk policy. On 19.1 percent of imminent risk calls, the counselors sent emergency services (police, sheriff, EMS) with the collaboration of the callers, while on a quarter of the imminent risk calls, the counselors sent emergency services without the caller's collaboration. For the remaining 55 percent of calls involving imminent risk, the risk level was able to be reduced without the use of police or ambulance through collaborative interventions,

such as reducing access to lethal means, involving a third party, collaborating on a safety plan, and agreeing to receive rapid follow-up from the crisis center.

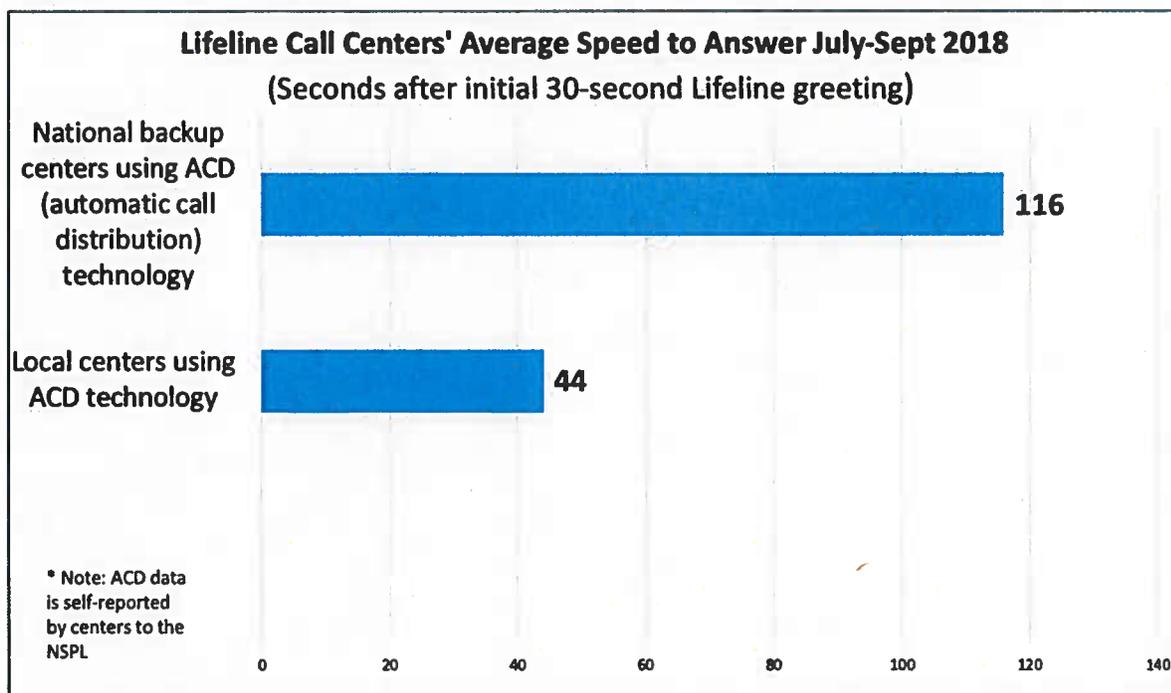
The evaluations also highlighted the need to heighten outreach strategies to minimize suicide risk and enhance referrals. Gould and colleagues (2007) found that 43 percent of suicidal callers who completed evaluation follow-up assessments experienced some recurrence of suicidality (ideation, plan, or attempt) in the weeks after their crisis call, and only 22.5 percent of suicidal callers had been seen by the mental health care system to which they had been referred. In response to these findings, SAMHSA funded an initiative in 2008 to offer and provide follow up to all Lifeline callers who reported suicidal desire during or within 48 hours before making a call to Lifeline. The follow-up was designed to enhance continuity of care during the high-risk period following a suicidal crisis. An evaluation of 550 callers followed by 41 crisis counselors from six crisis centers revealed that 79.6 percent of callers interviewed 6-12 weeks after their crisis call reported that the follow-up calls stopped them from killing themselves (53.8 percent a lot, 25.8 percent a little) (Gould, Lake, Galfalvy, Kleinman, Munfakh, Wright, & McKeon, R. (2018). Callers said follow-up gave them hope, made them feel cared about, and helped them connect to further mental health resources. These callers also reported that the initial crisis calls stopped them from killing themselves (76.2 percent a lot, 18.7 percent a little). Currently 119 of the Lifeline centers report providing some follow-up services, typically within 48 hours of the initial call. However, the majority of these centers do not receive any funding for the follow-up services (National Suicide Prevention Lifeline, 2017). Building upon evaluations of crisis centers' experience providing follow-up services to suicidal Lifeline callers, SAMHSA has funded Lifeline crisis centers to engage in follow-up activities with suicidal individuals discharged from emergency departments and hospitals. The evaluation of these expanded follow-up efforts are underway.

National Suicide Prevention Lifeline Challenges: The Need for Growth in Community Crisis Center Capacity to Meet Growing Volume

While evaluation of calls to the Lifeline have shown good results regarding effectiveness, including reduction of suicidal ideation and hopelessness, improved suicide risk assessment, response to callers at imminent risk, and improving follow up, the greatest challenge to the

effectiveness of the Lifeline is its capacity to respond rapidly to the steadily increasing call volume. Any call not responded to, or where the response is delayed long enough that a suicidal caller hangs up (call abandonment), has the potential for a tragic outcome. By providing a system of backup centers to local communities, the Lifeline has substantially improved crisis care in the United States. However, this system is challenged by both rising call volumes and uneven coverage in many states. This results in many calls going directly to the back-up centers, which are unable to respond as quickly as a local crisis center could.

Figure 2. National Suicide Prevention Lifeline Call Centers' Average Speed to Answer



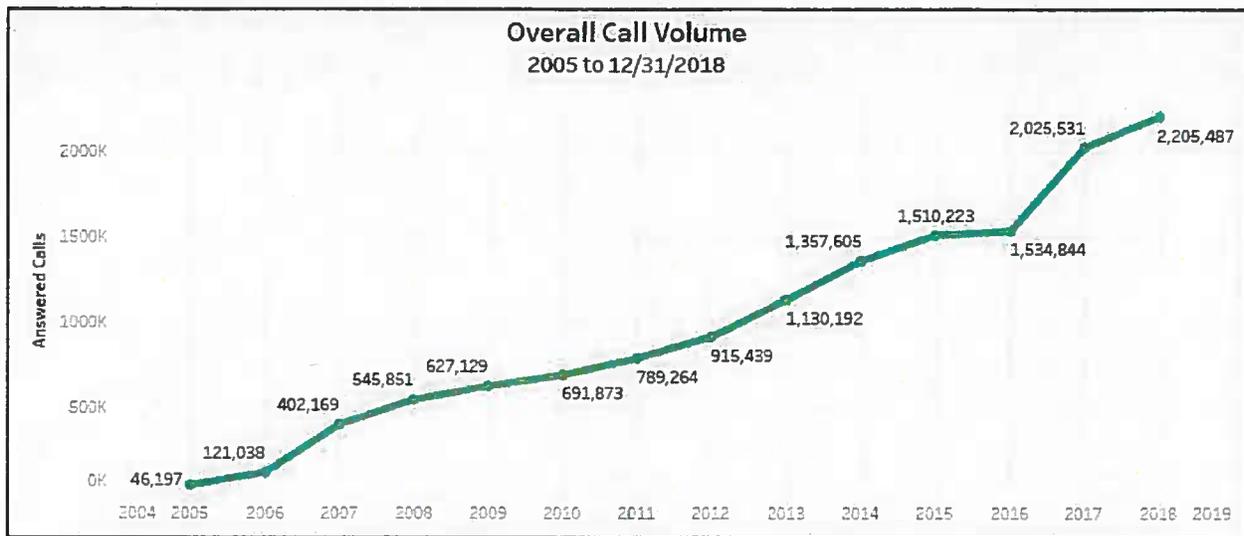
On average local Lifeline crisis centers answered calls within 44 seconds while the average speed to answer calls going to the Lifeline back up centers was 116 seconds. This illustrates the importance of increasing local Lifeline crisis center capacity. Some potential ways of accomplishing this would be by assisting centers to increase the number of staff available to answer calls or by adding more crisis centers to the Lifeline network to minimize areas that send calls directly to back up centers. From April 2017 to April 2018 the average longest wait increased 29 percent. Appendix 1 includes a table of the in state answer rate for every state (excluding callers who “press 1” to be connected to the VCL). The fiscal year 2019 increase of \$4.9 million in the Lifeline appropriation (to a total of \$12 million) will provide assistance in

increasing both local Lifeline and backup center call capacity to improve the average speed to answer for Lifeline calls, as well as to decrease the call abandonment rate.

The increased visibility of the Lifeline number through the media, internet, and social media has been a powerful driver of continuing increased call volume for the Lifeline. For example, individuals who use *Google* as their browser when searching for “suicide” or phrases indicating that they may be in danger (e.g., “ways to kill yourself”) receive an automated response at the top of their search results that says, “You’re not alone. Confidential help is available for free” and provides the Lifeline number. On *Apple iPhones*, the “Siri” system responds to “suicide” with the message, “If you are thinking about suicide, you may want to speak with someone at the Lifeline. They’re at 1-800-273-8255 (TALK). Shall I call them for you?” Online users who mention “suicide” in their postings to *Help.com* receive a response urging them to call 1-800-273-8255 (TALK). Another way that the Lifeline has recently expanded support systems available to individuals contemplating suicide is through the use of social media to raise awareness of its services, increase awareness of mental illness, spread hope, and educate communities about suicide prevention and prevention measures. Their work includes a strong presence on social networking sites (e.g., Facebook, Twitter, Tumblr, Pinterest, Myspace), as well as active relationships with social media organizations.

In addition to increased visibility of the Lifeline number online and through social media, high profile events such as suicides of Robin Williams, Kate Spade, and Anthony Bourdain; the publicizing of the Lifeline number on the Grammys with the Logic song “800-273-8255;” and the recent CDC reports of increasing suicide rates nationally have also led to increases in call volume that have been maintained over time. In light of the increasing attention to this issue, SAMHSA and its partners have widely promoted resources to educate and inform the media and journalists writing about suicide, including dissemination of *The Recommendations for Reporting on Suicide*, <http://reportingonsuicide.org/>. These efforts not only aim to improve the accuracy of reporting, but also often translates into additional advertising of the Lifeline number and other local and national crisis intervention resources.

Figure 3. National Suicide Prevention Lifeline Overall Call Volume



Year ⁷	Number of Answered Calls	Funding to the Lifeline
2005	46,197	\$3,052,000
2006	121,038	\$3,021,000
2007	402,169	\$4,484,000
2008	545,851	\$5,081,304
2009	627,129	\$4,484,000
2010	691,873	\$5,522,000
2011	789,264	\$5,522,000
2012	915,439	\$5,511,563
2013	1,130,192	\$6,071,062
2014	1,357,605	\$7,117,699
2015	1,510,223	\$7,198,000
2016	1,534,844	\$7,198,000
2017	2,025,531	\$7,198,000
2018	2,205,487	\$7,198,000

Potential Impact of an N11 Number on National Suicide Prevention and Crisis Intervention Efforts

Based on SAMHSA’s experience with national and state crisis intervention efforts over the past 18 years, and informed by a meeting of experts and stakeholders in mental health, crisis intervention, emergency services and suicide prevention that SAMHSA convened November 29 to 30, 2018,⁸ our judgment is that an N11 national suicide prevention number has the potential to

⁷ The ‘Number of Answered Calls’ refers to calendar year. The ‘Funding to the Lifeline’ refers to fiscal year.

⁸ See Appendix 3 for list of participants from the November 2018 expert stakeholder meeting.

play a key role in improving national crisis intervention and suicide prevention efforts; if the launch of a new number is accompanied by efforts to develop a more coordinated crisis system with greater capacity and access to sophisticated data and technology systems, and an ongoing commitment to data driven quality improvement.

The arguments in favor of an N11 national number, as articulated by mental health, crisis intervention, emergency services, and suicide prevention stakeholders at the stakeholder meeting convened by SAMHSA, appear to fall into two categories. One is the assertion that an N11 number would be easier to remember than a 10 digit number, and that this would lead to more people who are in need of help being able to access it. Of particular importance, it is also felt that remembering the number during a time of crisis would be enhanced for an N11 number. Cognitive access during a time of crisis is critical and impacted by the complexity of the information needed to be remembered. If a family member experiences severe chest pains in the company of another family member, both the patient and the family member, despite their heightened anxiety, would remember the number 911, while the concern is that many suicidal people or their family members at a similar moment of suicidal crisis might not remember 1-800-273-8255 (TALK). The issue of greater accessibility of an N11 number is currently being further explored by scientists in the psychology lab at Florida State University under the leadership of Dr. Thomas Joiner. Preliminary data suggest that an N11 number will be more effective than any other shortened dialing code. This is consistent with the possibility that, in the long run, N11 could be more effective than 1-800-273-TALK.

The fact that we can clearly document that many, many actively suicidal people call the Lifeline, at least 500,000 per year based on the Lifeline estimate of 25 percent of callers being suicidal at the time of the call, does not mean that there are not many others who could or would call if they only could remember the number at the moment they most need it. An N11 number should certainly be easier to remember than a 10 digit number, especially if the number is reinforced by repeated public awareness campaigns such as those that have led to 911 achieving such a high level of community awareness.

The second major argument in favor of an N11 number is the need for what has been called “a 911 for the brain.” This view, articulated by experts such as Michael Hogan, former Mental Health Commissioner in New York, Ohio, and Connecticut and former chair of President Bush’s

New Freedom Commission on Mental Health, is that compared to the system of emergency medical services in the United States of which 911 centers are a core component, crisis services in mental health are fragmented, poorly coordinated, under resourced, and at times even counterproductive for their stated goals of promoting health and safety. In this view, availability of an N11 number for mental health and suicide prevention could be a transformative step forward in the improvement of crisis systems in America. While an N11 number alone would not achieve such a transformation, the combination of the N11 number and the message that mental health crises and suicide prevention are of equivalent importance to medical emergencies would, over time, bring needed parity and could result in additional attention and resources to improve typical local psychiatric crisis services throughout our nation. This could accelerate a trend started already by a small number of states that have taken steps to dramatically improve their crisis systems.

While there is no exact analogy within a state that would help precisely anticipate the impact of an N11 national suicide prevention number, review of the experience with the launching of new statewide crisis numbers and new crisis systems is instructive. For example, in 2006, Georgia moved from a system of local crisis lines to a single statewide crisis line with a new statewide number, the Georgia Crisis and Access Line (GCAL), 1-800-715-4225. While it is not possible to tabulate the full volume of calls that were being answered by Georgia crisis lines pre-GCAL, Behavioral Health Link, which operates GCAL, believes it likely that the introduction of the statewide number and the accompanying public education campaign led to a significant increase in overall call volume. Perhaps of even greater importance, the introduction of a state wide number as a single point of access established GCAL as the hub of a coordinated crisis system that also dispatches mobile outreach services, monitors psychiatric bed capacity, provides outpatient appointments and can use sophisticated electronic dashboards to monitor patient movement and safety across the acute care and crisis system. The introduction of a state wide number did not by itself create these major steps forward, rather the consolidation of multiple hotline numbers into one statewide number became the linchpin and the crisis center the hub for a more coordinated, responsive, and accountable crisis response system.

Similarly, the state of Colorado launched a statewide number (844-493-TALK),⁹ which also, utilizing the Lifeline crisis center Rocky Mountain Crisis Partners, serves as a hub for several coordinated crisis services, including the ability to use the call center to provide telephonic follow up to suicidal persons leaving multiple Colorado emergency rooms. This effort has used a model that has been shown to result in significant reductions in suicidal behavior in two controlled studies (Miller, et. al., 2017 and Stanley, Brown et. al., 2018). The launch of the statewide number has also been associated with an increase in the total statewide crisis call volume. Colorado has also been building on this crisis center hub model to discourage the use of jails for mental health treatment and support transporting people to a crisis center rather than an emergency department.

One international experience may be instructive. In England, the move to 111 as the National Health Service urgent care number has been reported to be associated with a steady increase in demand over time (Pope, Turnbull, Jones, et. al., 2017).

Potential Impact of a New N11 Number on the National Suicide Prevention Lifeline

The language of the Act does not explicitly state what the precise relationship of an N11 number to the Lifeline should be. For example, the Lifeline could be separate from a new N11 suicide prevention number; a new N11 number could become the new Lifeline number; or an N11 number and the existing Lifeline number could both be portals into one unified system. Much of the dialog surrounding the Act, including feedback that SAMHSA received from the expert stakeholder meeting held in November 2018, has referenced the option of a new N11 number becoming the new number for the Lifeline. Federal and state experience with other legacy numbers suggests that if new numbers are developed, legacy numbers must be maintained. For example, SAMHSA's experience with 1-800-SUICIDE, as well as the experience with other legacy numbers in Georgia is that it can take many years, for call volume on no longer promoted hotline numbers to dwindle to the point where shutting them off would not be a threat to the public safety. SAMHSA committed to continuing support of the 1-800-SUICIDE number even though we were promoting 1-800-273-8255 (TALK) as the national suicide prevention number.

⁹ This number was utilized to build on consistency with the National Suicide Prevention Lifeline 1-800-273-8255 (TALK) number.

Although SAMHSA has not promoted 1-800-SUICIDE since 2007, the Lifeline still receives an average of 178,864 calls annually that are routed from 1-800-SUICIDE. The increased exposure of the Lifeline number, 1-800-273-8255 (TALK), online and through social media, which greatly exceeds the previous internet presence of 1-800-SUICIDE, indicates that 1-800-273-8255 (TALK) will likely continue to be a vital suicide prevention hotline number. If an N11 number was disconnected from the Lifeline, this would needlessly divide the nation's efforts to improve crisis response. The best option would be the value added to the existing Lifeline efforts by the establishment of an N11 number that would also be a portal into the Lifeline network. In our judgment, this would have the potential for reaching significantly more people at risk for suicide and to significantly enhance crisis services.

911, 211, and 611 Significance for the National Suicide Prevention Lifeline

In discussions at SAMHSA's November 2018 expert stakeholder meeting, it was clear that in the mental health and suicide prevention communities 911 is viewed as the gold standard for crisis response. Even among mental health providers and programs the statement "If this is an emergency, call 911" is commonly the recorded message most will hear if unable to reach a provider. A "911 for the brain" model could potentially have many advantages. As described by the Office of Emergency Services in the National Highway Transportation Administration, over the past 40 years a national vision of comprehensive, evidence-based emergency medical services and 911 systems that is inherently safe, effective, integrated, seamless, and socially equitable has driven positive change. Yet, even after 40 years of progress, the 911 system while pervasive across America, does not exist in every county. While 911 is not perfect, no one would seriously argue about returning to a time before 911 and its pivotal role in a national effort to dramatically improve emergency medical services. A crucial observation here is that while assignment by the FCC of 911 as a national emergency number did not in and of itself create an evolving and improving emergency medical response system, the 911 number has undoubtedly played a critical role in catalyzing the development of these services, in the same way that the statewide numbers in Georgia and Colorado have played a pivotal role in improving crisis services in those states.

The rapid dispatching of ambulance and EMTs through 911 is vitally important when someone has made a suicide attempt. The capacity of 911 centers to utilize geolocation technology to identify the physical location of an individual who has made a suicide attempt is a significant advantage that 911 centers have over the current Lifeline, particularly in a time when cell phones are so common. Though contacting 911 to dispatch police or ambulance may be necessary in some circumstances where there is a high imminent risk of suicide, many calls related to suicidal ideation are able to be addressed with talk alone and without the dispatching of a first responder. The ability of the Lifeline crisis center to provide telephonic crisis intervention, referral, and follow up may be sufficient to avoid ambulance and police dispatch and transport to overcrowded emergency departments. For example, collaborations such as the Harris Center in Houston's colocation with 911 services allows many 911 callers to be seamlessly responded to by a Lifeline call center. Similarly, the backup system of crisis centers that currently exists within the Lifeline is an advantage that 911 centers do not have. While 911 might not be a perfect model for suicide prevention, there are likely many lessons that can be adapted from the emergency medical services experiences that could improve crisis intervention and suicide prevention in the United States.

In addition to 911, 211, which is the national information and referral number, has also been suggested as a potential model for suicide prevention. Forty of the 163 Lifeline crisis centers are currently blended 211/crisis centers, meaning those centers have both information and referral and crisis response capacity. Suicidal callers frequently need an array of community services. So this connection has numerous advantages in making community connections. However, not all 211 centers have crisis capacity and the number 211 is associated with information and referral, which, while valuable, does not communicate that this number is a number that suicidal people or their families can call at any time of the day or night for immediate crisis intervention. In other words, the numbers 211 do not communicate a crisis or emergency service in the way that 911 does. In addition, using 211 as the national suicide prevention number would involve combining two different functions, one urgent or emergent and the other not. A crisis number needs to have unique characteristics, including availability 24 hours a day, seven days a week, 365 days a year. In addition, calling the number should result in rapid response and the number should be widely recognized as a crisis number, these are not typically characteristics associated with 211 as a number.

In SAMHSA's experience, utilizing one number for a dual purpose has not been successful. Specifically, in the wake of Hurricane Katrina, which was prior to the establishment of SAMHSA's National Disaster Distress Helpline, the Lifeline number was also used for disaster mental health crisis. Many individuals in post disaster distress did not understand why they were being encouraged to call a suicide hotline, but to have taken the word suicide out of the Lifeline's recorded message would have been to risk compromising its basic function.

Numerous participants at SAMHSA's November 2018 expert stakeholder meeting proposed 611 as the most likely and potentially available N11 number. The establishment of 611 or an alternative N11 number for suicide prevention and crisis intervention would also have the potential, because it would be designated for urgent or emergent crisis situations, to be utilized as an alternative to 911 by primary care offices or other health providers. Such providers might otherwise contact 911 anytime they encounter a person expressing suicidal ideation. Because such an N11 number would not be linked to near automatic dispatch of ambulance or police there could be a reduction in unnecessary emergency department use.

In summary, the establishment of an N11 national suicide prevention number may be a critical catalyst in the transformation of the nation's psychiatric emergency and crisis system in the same way that the establishment of 911 has led to an ongoing transformation of the nation's emergency medical system. The establishment of an N11 phone number has the potential to significantly increase the number of people in suicidal crisis who are helped and assist crisis centers to become the central hub for an improved community crisis system. To make this vision a reality would require more than an N11 number. It would require a coordinated effort between the federal government, states, the health care system, and many others to fill the gaps in our current systems and help halt the tragic rise in suicide across the country. It would also require careful analysis by states, potentially in consultation with SAMHSA, of the necessary crisis center capacity to answer current and projected call volume safely and effectively, as well as a commitment to ongoing, data driven quality improvement efforts.

Recommendations for Improving the Lifeline

Increased public education and awareness

If an N11 number is assigned by the FCC, a public education and awareness campaign to publicize the new number would be instrumental in encouraging the use of the new number. Implementation of such a campaign should be done in coordination with ramped up capacity to respond to these calls. An example of this approach that is instructive was New York City's simultaneous public awareness campaign with the upscaling of the LifeNet Crisis Center. The reach of the campaign could be tracked by looking at call volume data in the targeted areas. Regardless of whether an N11 number is assigned, public education regarding when to call 911 versus when to call the Lifeline could potentially be of benefit in increasing access while decreasing emergency department utilization.

Education focused on state and local policy makers to correct the misunderstanding that the Lifeline is a centrally located federally funded large crisis center, rather than a decentralized system that relies on community crisis center capacity and local resources, would also be important. Greater recognition that the Lifeline rests on the shoulders of 163 local crisis centers could lead to greater support and increased capacity for these crisis centers who comprise the nation's safety net for suicidal persons.

Improved infrastructure and operations

As previously described, the major challenge regarding Lifeline's infrastructure and operations is the need to expand Lifeline's community crisis center capacity, either by adding more crisis centers to the network or by resourcing existing crisis centers to expand their coverage areas. States such as Colorado and Utah invested in their crisis systems and provide support to have Lifeline calls answered and as a result have most of their Lifeline calls answered in state. Some changes to the Lifeline infrastructure were suggested at the November meeting convened by SAMHSA. For example, one suggestion was funding 1-3 large crisis centers to answer calls in a manner similar to what the VA has done in establishing 3 large crisis centers to answer VCL calls. This would require a very significant expansion of SAMHSA funding and would lose the connection to local emergency and mental health resources that exists in the current system. Others at the meeting have pointed to the consolidation of poison control centers in the U.S. as a

model which led to better funding and greater capacity. This Poison Control model has advantages that could benefit the Lifeline if adapted, such as, the shared use of specialized professionals, such as toxicologists, and the close links to emergency departments and other health care facilities. Closer linkages between the Lifeline crisis centers with the health and mental health systems would be a great advantage. While currently some centers are deeply embedded in their state's health care system (e.g. Georgia, Colorado, Arizona), other centers are much more detached. Connections to advanced data systems and technologies as called for in the Crisis Now model would also be significant, including enhanced telehealth capacities (National Action Alliance for Suicide Prevention: Crisis Services Task Force, 2016). Adding geolocation capacities would also be a significant improvement to better enable locating acutely suicidal individuals who have made suicide attempts or who are at imminent risk of doing so.

Continued attention to data driven improvement efforts, such as those that led to the development of the Lifeline's Standards for Suicide Risk Assessment and the Guidelines for Callers at Imminent Risk, are important, but can also be expanded to more effectively follow up with suicidal individuals who currently become lost between the fragmented components of our systems. Making Lifeline centers the hub of more coordinated crisis systems with what the Crisis Now model calls Air Traffic Control Capacity — the ability to track and not lose suicidal people during acute care transitions — could ideally become a crucial performance improvement metric, as vitally important as call abandonment rates or call response time.

Finally, it is noted that 911 and the emergency medical services system has a federal home and locus for envisioning and driving forward improvements across the nation, in a way that currently does not exist for psychiatric emergency and crisis services. SAMHSA's efforts with its Lifeline Steering Committee is probably the closest effort currently. A federal effort modeled on the Office of Emergency Medical Services (housed in the Department of Transportation) could serve a key role in helping to achieve the kind of transformative impact for which 911 is the exemplar.

Cost Considerations

In addition to the costs that will be evaluated by the FCC, such as the costs of translation changes, cell site analysis, and reprogramming by wireless carriers, there are other very relevant

cost considerations associated with responding to increased volume of crisis calls. The Lifeline estimated that the cost for a high performing crisis center to respond to a crisis call would be approximately \$25 per call (National Suicide Prevention Lifeline, 2018). Based on this estimate, if the ease of use of an N11 number led to a 100 percent increase in the number of crisis calls (or approximately an additional two million calls), the additional cost for this capacity would be \$50 million. If each suicidal caller were to receive telephonic follow up until connected to care, a study estimated that there would be a 2 to 1 return on investment because of reduced emergency department and hospitalization costs (Richardson, Mark, McKeon, 2014). Similarly another recent study showed that telephonic follow up of suicidal people leaving emergency departments was cost effective compared to usual care for these same reasons at a cost of \$4300 per life year saved annually (Denchev, Pearson, Allen, et.al, 2018). Increasing funding by about \$50 million would enable the current system to increase capacity to manage anticipated call volume and is likely to be associated with cost offset or savings through reduced emergency department visits and avoidable hospitalizations.

References

- Denchev, P., Pearson, J.L., Allen, M.H., Claassen, C.A., Currier, G.W., Zatzick, D.F., Schoenbaum, M. (2018). Modeling the cost-effectiveness of interventions to reduce suicide risk among hospital emergency department patients. *Psychiatric Services*, 69(1), 23-31.
- Gould, M. S., Cross, W., Pisani, A. R., Munfakh, J. L. H., & Kleinman, M. (2013) Impact of applied suicide intervention skills training on the National Suicide Prevention Lifeline. *Suicide and Life-Threatening Behavior*, 43(6), 676–691.
- Gould, M. S., Lake, A. M., Galfalvy, H., Kleinman, M., Munfakh, J. L. H., Wright, J., & McKeon, R. (2018). Follow-up with callers to the National Suicide Prevention Lifeline: Evaluation of callers' perceptions of care. *Suicide and Life-Threatening Behavior*, 48(1), 75–86. doi:10.1111/sltb.12339 (Posted online: March 6, 2017)
- Gould, M. S., Lake, A. M., Munfakh, J. L., Galfalvy, H., Kleinman, M., Williams, C., McKeon, R. (2016). Helping callers to the National Suicide Prevention Lifeline who are at imminent risk of suicide: Evaluation of caller risk profiles and interventions implemented. *Suicide and Life-Threatening Behavior*, 46(2), 172–190.
- Gould, M. S., Munfakh, J. L. H., Kleinman, M., & Lake, A. M. (2012). National Suicide Prevention Lifeline: Enhancing mental health care for suicidal individuals and other people in crisis. *Suicide and Life-Threatening Behavior*, 42(1), 22–35.
- Gould, M.S., Kalafat, J., Munfakh, J.L.H. & Kleinman, M. (2007). An evaluation of crisis hotline outcomes, Part II: Suicidal Callers. *Suicide and Life Threatening Behavior*, 37(3), 338-352.
- Hedegaard H, Curtin SC, Warner M. Suicide mortality in the United States, 1999–2017. NCHS Data Brief, no 330. Hyattsville, MD: National Center for Health Statistics. 2018.
- Joiner, T. E., Kalafat, J., Draper, J., Stokes, H., Knudson, M., Berman, A. L., et al. (2007). Establishing standards for the assessment of suicide risk among callers to the National Suicide Prevention Lifeline. *Suicide and Life-Threatening Behavior*, 37, 353–365.
- Kalafat, J., Gould, M.S., Munfakh, J.L.H. & Kleinman, M. (2007). An evaluation of crisis hotline outcomes, Part I: Non-Suicidal Crisis Callers. *Suicide and Life Threatening Behavior*, 37(3), 322-337.
- LivingWorks. (2010). Retrieved from <http://www.livingworks.net/>.
- Miller, I.W., Camargo, C.A. Jr., Arias S.A., Sullivan, A.F., Allen M.H., Goldstein A.B., Manton A.P., Espinola J.A., Jones R., Hasegawa, K., Boudreaux E.D. (2017). Suicide prevention in an emergency department population: The ED-safe study. *JAMA Psychiatry*, 74(4), 563-570.

Mishara, B.L., Chagnon, F., Daigle, M., Balan, M., Raymond, S., Marcoux, I., Bardon, C., Campbell, J.K., & Berman, A. (2007a). Which Helper Behaviors and Intervention Styles are Related to Better Short Term Outcomes in Telephone Crisis Intervention? Results from a Silent Monitoring Study of Calls to the U.S. 1-800-SUICIDE Network. *Suicide and Life Threatening Behavior*, 37(3), 291- 307.

Mishara, B.L., Chagnon, F., Daigle, M., Balan, M., Raymond, S., Marcoux, I., Bardon, C., Campbell, J.K., & Berman, A. (2007b). Comparing Models of Helper Behavior to Actual Practice in Telephone Crisis Intervention: a Silent Monitoring Study of Calls to the U.S. 1-800-SUICIDE Network. *Suicide and Life Threatening Behavior*, 37(3), 308-321.

Murphy SL, Xu JQ, Kochanek KD, Arias E. Mortality in the United States, 2017. NCHS Data Brief, no 328. Hyattsville, MD: National Center for Health Statistics. 2018.

National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). *Crisis now: Transforming services is within our reach*. Washington, DC: Education Development Center, Inc.

National Suicide Prevention Lifeline. (2018). Lifeline network development and the national suicide hotline improvement act of 2018 [Power Point Slides]. Retrieved via email correspondence August 2, 2018.

National Suicide Prevention Lifeline. (2017). *Crisis Center Follow-Up Survey Results October 2017*. [Summary Report]. New York, NY: Vibrant Emotional Health.

Pope, C., Turnbull, J., Jones J., Prichard, J., Rowsell A., Halford, S. (2017). Has the NHS 111 urgent care telephone service been a success? Case study and secondary data analysis in England. *BMJ Open*, 7:e014815. doi: 10.1136/bmjopen-2016-014815

Richardson, J.S., Mark, T., McKeon, R. (2014). The return on investment of postdischarge follow-up calls for suicidal ideation or deliberate self-harm. *Psychiatric Services*, 65(8), 1012-1019.

Ramchand, R., Jaycox, L., Ebner, P., Gilbert, M., Barnes-Proby, D., & Goutam, P. (2017). Characteristics and Proximal Outcomes of Calls Made to Suicide Crisis Hotlines in California. *Crisis*, 38, 26-35.

Stanley, B., Brown, G.K., Brenner L.A., Galfalvy, H.C., Currier, G.W., Knox, K.L., Chaudhury, S.R., Bush, A.L., Green, K.L. (2018). Comparison of the safety planning intervention with follow-up vs. usual care of suicidal patients treated in the emergency department. *JAMA Psychiatry*, 75(9), 894-900.

Stone DM, Simon TR, Fowler KA, et al. *Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015*. MMWR Morb Mortal Wkly Rep 2018;67:617–624. DOI: <http://dx.doi.org/10.15585/mmwr.mm6722a1>.

Straus, J. H., Sarvet, B. (2014). Behavioral health care for children: The Massachusetts child psychiatry access project. *Health Affairs*, 33(12), 2153-2161.

U.S. Department of Health and Human Services, Office of the Surgeon General, and the National Action Alliance for Suicide Prevention. (2012). 2012 National strategy for suicide prevention: Goals and objectives for action. Washington, DC: U.S. Department of Health and Human Services.

Appendix 1: National Suicide Prevention Lifeline In-State Answer Rate

In-State Answer Rate by Originating State, 7/1/2018 to 9/30/2018

State	In-State Answered Rate ^a
Alabama	64%
Alaska	68%
Arizona	93%
Arkansas	57%
California	87%
Colorado	84%
Connecticut	88%
Delaware	87%
District of Columbia	56%
Florida	77%
Georgia	22%
Hawaii	90%
Idaho	76%
Illinois	27%
Indiana	57%
Iowa	66%
Kansas	63%
Kentucky	29%
Louisiana	73%
Maine	94%
Maryland	90%
Massachusetts	65%
Michigan	36%
Minnesota	2%
Mississippi	80%
Missouri	87%
Montana	82%
Nebraska	72%
Nevada	54%
New Hampshire	70%
New Jersey	83%
New Mexico	83%
New York	40%
North Carolina	88%
North Dakota	82%
Ohio	70%
Oklahoma	79%
Oregon	79%

Pennsylvania	37%
Rhode Island	17%
South Carolina	12%
South Dakota	95%
Tennessee	68%
Texas	24%
Utah	95%
Vermont	5%
Virginia	57%
Washington	78%
West Virginia	70%
Wisconsin	30%
Wyoming	0%

^a These percentages exclude callers who “press 1” to be connected to the Veterans Crisis line.

Appendix 2: 21st Century Cures Act – Section 9005: National Suicide Prevention Lifeline Program

SEC. 9005. NATIONAL SUICIDE PREVENTION LIFELINE PROGRAM. Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.) is amended by inserting after section 520E–2 (42 U.S.C. 290bb–36b) the following: “**SEC. 520E–3. NATIONAL SUICIDE PREVENTION LIFELINE PROGRAM.** “(a) **IN GENERAL.**—The Secretary, acting through the Assistant Secretary, shall maintain the National Suicide Prevention Lifeline program (referred to in this section as the ‘program’), authorized under section 520A and in effect prior to the date of enactment of the Helping Families in Mental Health Crisis Reform Act of 2016. “(b) **ACTIVITIES.**—In maintaining the program, the activities of the Secretary shall include— “(1) coordinating a network of crisis centers across the United States for providing suicide prevention and crisis intervention services to individuals seeking help at any time, day or night; “(2) maintaining a suicide prevention hotline to link callers to local emergency, mental health, and social services resources; and “(3) consulting with the Secretary of Veterans Affairs to ensure that veterans calling the suicide prevention hotline have access to a specialized veterans’ suicide prevention hotline. “(c) **AUTHORIZATION OF APPROPRIATIONS.**—To carry out this section, there are authorized to be appropriated \$7,198,000 for each of fiscal years 2018 through 2022.”

Appendix 3: National Suicide Hotline Improvement Act Expert Stakeholder Meeting Participant List

National Suicide Hotline Improvement Act Meeting
November 29-30, 2018
PARTICIPANT'S LIST

ATTENDEES

Michael Allen
Rocky Mountain Crisis Center
michael.allen@ucdenver.edu

Jennifer Battle
Harris Center
jennifer.battle@theharriscenter.org

Sam Brinton
The Trevor Project
sam.brinton@thetrevorproject.org

Colleen Carr
Education Development Center, Inc.
ccarr@edc.org

David Covington
RI International
david.covington@riinternational.com

Colleen Creighton
American Association of Suicidology
ccreighton@suicidology.org

Kita Curry
Didi Hirsh Mental Health Services
kcurry@didihirsch.org

Jeffrey Davis
American College of Emergency Physicians
jdavis@acep.org

Michelle Dirst
American Psychiatric Association
mdirst@psych.org

Ashby Dodge
Vibrant Emotional Health
adodge@vibrant.org

John Draper
Vibrant Emotional Health
JohnD@vibrant.org

Katherine Elkins
National Highway Traffic Safety
Administration
katherine.elkins@dot.gov

Pam End of Horn
Indian Health Service
pamela.endofhorn@ihs.gov

Lynda Gargan
National Federation of Families for
Children's Mental Health
lgargan@ffcmh.org

Madelyn Gould
New York State Psychiatric Institute
madelyn.gould@nyspi.columbia.edu

Tristan Gorrindo
American Psychiatric Association
tgorrindo@psych.org

Deborah Hobbs
American Psychiatric Nurses Association
dhobbs@apna.org

Dwight Holton
Lines for Life
dwighth@linesforlife.org

Roshni Janakiraman
Florida State University
janakiraman@psy.fsu.edu

Connor Jobses
American Foundation for Suicide Prevention
cjobses@afsp.org

Marilyn Jones
Federal Communications Commission
marilyn.jones@fcc.gov

Savannah Kalman
SAMHSA
savannah.kalman@samhsa.hhs.gov

Stephen Kaminski
American Association of Poison Control
Centers
kaminski@aapcc.org

Tracy Kennedy
Real Crisis Services
tskennedy@embarqmail.com

Angela Kimball
National Alliance on Mental Illness -
ISMICC
akimball@nami.org

David Koosis
Vibrant Emotional Health
dkoosis@vibrant.org

Kristin Kroeger
American Psychiatric Association
kkroeger@psych.org

Celia Lewis
Federal Communications Commission
celia.lewis@fcc.gov

John Madigan
American Foundation for Suicide Prevention
jmadigan@afsp.org

Christy Malik
National Association of State Mental Health
Program Directors
christy.malik@nasmhpd.org

Richard McKeon
SAMHSA
richard.mckeon@samhsa.hhs.gov

Matthew Miller
Veterans Crisis Line
matthew.miller8@va.gov

Kimberly Mullen
Veterans Crisis Line
Kimberly.Mullen2@va.gov

Monica Nemec
Centerstone America
Monica.Nemec@centerstone.org

Craig Obey
American Psychiatric Association
cobey@psych.org

Jane Pearson
NIMH
jpearson@mail.nih.gov

Rajeev Ramchand
Cohen Veterans Network
rajeev.ramchand@cohenveteransnetwork.org

Jerry Reed
Education Development Center, Inc.
jreed@edc.org

Brie Reimann
National Council for Behavioral Health
communications@thenationalcouncil.org

Catherine Reynolds
Mental Health America
creynolds@mentalhealthamerica.net

Loren Rives
American College of Emergency Physicians
lrives@acep.org

Jack Rozel
American Association for Emergency
Psychiatry
rozeljs@upmc.edu

Sandra Schneider
American College of Emergency Physicians
sschneider@acep.org

Michelle Sclater
Federal Communications Commission
michelle.sclater@fcc.gov

Shari Sinwelski
Vibrant Emotional Health
ssinwelski@vibrant.org

Matt Taylor
Vibrant Emotional Health
mtaylor@vibrant.org

Caitlin Thompson
Cohen Veterans Network
Caitlin.thompson@cohenveteransnetwork.org

James Wright
Veterans Crisis Line
James.wright@va.gov

APPENDIX B
THE U.S. DEPARTMENT OF VETERANS AFFAIRS (VA) REPORT

**U.S. Department of Veterans Affairs
Veterans Health Administration**



**Public Law 115-233
August 14, 2018
H.R. 2345**

“National Suicide Hotline Improvement Act of 2018”

Table of Contents

Executive Summary:	3
Introduction & Background	3
VCL Mission and Description	4
Relationship with SAMHSA / V!brant.....	5
VCL Call Flow Process.....	6
VCL Quality Assurance Plan	7
VCL's Ability to Respond to Veterans.....	11
Oversight and Accreditation	14
Community Outreach and Engagement	15

National Suicide Hotline Improvement

Executive Summary:

On August 14, 2018, President Trump signed into law the National Suicide Hotline Improvement (Public Law (P.L.)115-233). The legislation requires the Federal Communications Commission to study the feasibility of designating a simple, easy-to-remember dialing code to be used for a national suicide prevention and mental health crisis hotline system. The study must be completed in coordination with the Assistant Secretary for Mental Health and Substance Use at the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Secretary of Veterans Affairs (VA). The VA must submit a report to the Commission on how well the National Suicide Prevention Lifeline and the Veterans Crisis Line (VCL) is working to address the needs of veterans. If the Commission recommends that a dialing code should be used upon receiving the initial reports from the Assistant Secretary for Mental Health and Substance Use and the Secretary of Veterans Affairs, the report shall include logistics, recommendations and estimated cost of designating the dialing code. The report shall also include a cost-benefit analysis comparing the dialing code with the National Suicide Prevention Lifeline and other recommendations for improving the Lifeline in general (e.g. public education and awareness, improved infrastructure and operations). The VCL has set quality and service metrics that are inline with, meet or exceed standards of the National Emergency Numbers Association, accrediting bodies in facility and crisis management, and those collected by organizations such as the National Suicide Prevention Lifeline and its crisis centers. The VCL has expanded the ability to respond to Veterans needs by increasing the amount of call centers and responders, drastically lowering the amount of calls unable to be answered by the primary system, decreasing the time to respond once received, and decreasing the rate of calls abandoned. A robust quality management system is in place to ensure fidelity to all policies and procedures across services provided by the VCL and identify opportunities for continued service improvement.

Introduction & Background:

On August 14, 2018, President Trump signed into law the National Suicide Hotline Improvement (Public Law (P.L.)115-233). The legislation requires the Federal Communications Commission to study the feasibility of designating a simple, easy-to-remember dialing code to be used for a national suicide prevention and mental health crisis hotline system. The study must be completed in coordination with the Assistant Secretary for Mental Health and Substance Use and the Secretary of Veterans Affairs (VA). The VA must submit a report to the Commission on how well the National Suicide Prevention Lifeline and the Veterans Crisis Line (VCL) is working to address the needs of veterans. If the Commission recommends that a dialing code should be used upon receiving the initial reports from the Assistant Secretary for Mental Health and Substance Use and the Secretary of Veterans Affairs, the report shall also include

logistics, recommendations and estimated cost of designating the dialing code. The report shall also include a cost-benefit analysis comparing the dialing code with the National Suicide Prevention Lifeline and other recommendations for improving the Lifeline in general (e.g. public education and awareness, improved infrastructure and operations).

VCL Mission and Description

The mission of the Veterans Crisis Line (VCL) is to provide 24/7, world-class suicide prevention and crisis intervention services to Veterans, Service members, and their family members. The VCL will provide supportive, timely, high quality crisis intervention services and connect Service Members, Veterans and their families to the services of their choice to ensure that they never struggle alone. The VCL can be reached via phone by dialing 1-800-273-8255 and pressing option 1, via text at 838255, and via online chat by visiting www.veteranscrisisline.net. Caring and qualified responders are standing by to help, 24/7/365. To ensure care coordination, the VCL collaborates with a network of over 400 Suicide Prevention Coordinators (SPCs), located at VA facilities across the nation. Upon completion of a call to VCL, an electronic consult may be submitted to the location nearest to the Veteran. The Veteran's local SPC will respond to this consult within 24 business hours; In FY2018, approximately 95% of SPC Consults have been responded to within one business day and closed within 3 business days.

The VCL is comprised of 3 linked call centers in Canandaigua, New York, Atlanta, Georgia, and Topeka, Kansas. The call center in Canandaigua, New York was established in 2007 and consists of more than 340 employees. All three core services (phone, chat and text) are provided from this location. The call center in Atlanta, Georgia was established in 2016 and consists of more than 360 employees. The call center in Topeka, Kansas was established in 2018 and has more than 80 employees. Currently both call centers in Kansas and Georgia provide phone services, with plans for future expansion into chat and text.

Since its launch in 2007, the Veterans Crisis Line has answered more than 3.8 million calls and initiated the dispatch of emergency services to callers in imminent crisis nearly 112,000 times. Since launching chat in 2009 and text services in November 2011, the VCL has answered more than 439,000 chats and nearly 108,000 texts. Staff have forwarded more than 640,000 referrals to local VA Suicide Prevention Coordinators on behalf of Veterans to ensure continuity of care with Veterans local VA providers.

High level monitoring/KPIs:

The VCL monitors performance via the Executive Leadership Council (ELC), consisting of boards focusing on Quality, Employee Experience, Customer Experience, Business Operations, and Partnerships, with Key Performance Indicators (KPIs) identified and tracked for each. Utilizing the Quadruple Aim, VCL monitors Access (Demand, Call

typing, rollover, abandonment, average speed to answer, and service level), Quality (Silent Monitoring results, Responder Dashboards, and Effectiveness), Cost (Vacancy percentage, agent utilization, leave, and overtime trends), and Experience (All Employee Survey results, Wellness, Caller feedback, and Average Handle time). Quadruple Aim data is reported monthly through the ELC.

Press 7:

VCL is continuing to expand access to meet the needs of Veterans and Service members in crisis, including full implementation of an automatic transfer function that directly connects Veterans who call their local VA Medical Center (VAMC) to VCL by pressing a single digit (7) during the initial automated phone greeting. Currently, this feature is available at all VAMCs and more than 85% of all Community Based Outpatient Clinics.

Relationship with SAMHSA / V!brant:

When the Veterans Crisis Line first started in 2007, the mission was to ensure Veterans in crisis would call and reach the VA directly through an internal crisis hotline. One way to accomplish this was to build off of the other federally supported crisis hotline, the existing National Suicide Prevention Lifeline number, 1-800-273-TALK (8255). This was beneficial because the phone system/structure was already in place, the number was well advertised, and it ensured that all individuals in the United States had one unified number to reach care. This allowed Veterans to immediately contact the VCL because the 1-800 number states, "if you are a Veteran, press 1" within the first 20 to 30 seconds of the call. This also allowed for cross promotion and access between the Veteran Crisis Line and the National Suicide Prevention Lifeline Crisis Centers. The 1-800-273-8255 number is federally funded by SAMHSA and currently operated through a cooperative agreement with V!brant Emotional Health. Since that time, the VCL has advertised the number on buses, bridges, billboards, and in public service announcements. The VCL has also been double branded as the Military Crisis Line for our Active Duty Service members.

In order to ensure this level of enhanced suicide prevention and crisis intervention services for all Veterans, Service members and their families, the VHA and SAMHSA entered in to an Inter-Agency Agreement (IAA). The purposes of this IAA are to ensure Veterans, Service members and their families have continuous access to the VCL through the 1800-273-TALK(8255) press 1 option and to work to prevent suicide deaths and attempts among Veterans, Service members and their families, including those that are not receiving Veterans Health Administration (VHA) care. The IAA also promotes innovation and fosters the spread of clinical and public health best practices for

preventing suicidal behavior among Veterans, Service members and their families, whether they receive care within the VHA or in community settings, and stipulates SAMHSA and the VCL regularly share data collection processes and analysis of information collected, including a focus on why Veteran callers do not press option 1 to be connected to the VCL.

The VCL also maintains a contract with Vibrant Emotional Health to ensure back-up coverage for the VCL calls that are unable to be answered at the VCL's three locations. This contract allows for an additional layer of security if there are catastrophic events, technical or call demand issues causing difficulty for the VCL network to respond. A Veteran amendment is written into the contract that provides any Lifeline centers that sign the amendment a \$1,000 stipend. The Centers agree to ask each caller if they are a Veteran and, after an assessment, if they would like to be warm transferred to the VCL. Vibrant provides a report to the VCL on the amount of veterans that are interacted with based on the veteran stipend.

VCL Call Flow Process

The Veterans Crisis Line's current call flow has evolved over the years, primarily in response to the need to be proactive in providing the most accessible access to care for Veterans, Service members and their families.

There are 3 primary paths of entry into the VCL:

- a. By dialing 800-273-TALK (8255) and Press 1
- b. By calling any VA Medical Center and/or currently 85% of all Community Based Outpatient Centers (CBOCs) and Press 7
- c. Receive a direct warm transfer from another agency/department

Calls are routed to the Responder who has been available for the longest period of time among the three sites; if no Responders become available after 237 seconds, the call will route to the contracted backup center, Lines for Life. If those calls are not answered by Lines for Life within 120 seconds, they then get routed to a high priority queue back at the VCL. If the high priority call is not answered in 3 rings, the call is moved into the main VCL call center traffic. It should be noted that the contingent routing described is very rarely, if ever, implemented in full, but remains a necessary and viable option to assure all calls get answered.

VCL Quality Assurance Plan

In accordance with the mission of the VCL and a critical component of the Quadruple Aim, Quality of Service is essential in providing world-class care to those the VA is serving. The VCL collects and reviews metrics for all phone calls, including those that are answered at the back-up crisis center. The VCL has developed key performance indicators (KPIs), which allow the organization to track and trend performance, including performance at the contracted back-up call center. These indicators are included in the Quality Assurance Plan with performance targets and are consistent with universal standards established by the [National Emergency Number Association \(NENA\)](#). These data are used to identify any areas needing improvement and forecast scheduling/staffing requirements. The Quality Assurance Activities, along with the KPIs and targets are as follows:

Quality Assurance Activities

Metrics for Answering Phones

The VCL collects and reviews metrics for all phone calls, including those that are answered at the back-up crisis center. These data are used to identify any areas needing improvement and forecast scheduling/staffing requirements.

Key Performance Indicator	Definition	Current Status	Target
Inbound volume	Total Calls Offered at all VCL locations	Reviewed daily, reported monthly	No Target
Telephone Inbound Service Level	Calls Answered within 20 seconds / Total Calls Answered	Currently meeting target; Reviewed daily, reported monthly	95% answered within 20 seconds
Abandonment Rate	% of inbound calls abandoned after being offered to either VCL location	Currently meeting target; Reviewed daily, reported monthly	5% or less

Metrics for Answering Chat

Metrics for VCL Chat mirror those reported for phone calls with the exception of rollovers as VCL Chat does not have back-up.

Key Performance Indicator	Definition	Current Status	Target
Chat Inbound Volume	Total chats offered	Reviewed and reported monthly	No Target
Chat Service Level	Time spent from time chat request is received until chat is answered by a responder	Currently meeting target; Reviewed and reported monthly	95% answered within 20 seconds

Metrics for Answering Text

Metrics for text mirror those reported for VCL Chat.

Key Performance Indicator	Definition	Current Status	Target
Text Inbound Volume	Total texts offered	Reviewed and reported monthly	No Target
Text Service Level	Time spent from time text request is received until text is answered by a responder	Currently meeting target; Reviewed and reported monthly	Target 95% answered within 45 seconds

Back-up Center Performance

If the performance of the back-up center does not meet the terms and conditions of the contract, the Contracting Officer has the authority to enact any contractual remedies set forth in the Federal Acquisition Regulations such as a letter of concern, cure notice, and termination for default.

Key Performance Indicator	Definition	Current Status	Target
Calls Presented (Back-up Center)	Number of calls routinely offered to back-up center during staffed hours	Reported and Reviewed weekly	0
Telephone Inbound Service Level (Back-up Center)	Number of calls within 20 seconds/Number of calls presented to the back-up center during staffed hours	Reported and Reviewed weekly	95% answered within 20 seconds
Abandonment Rate (Back-up Center)	% of all calls presented to the back-up center that are abandoned during staffed hours	Weekly/Monthly	5% or less

Clinical Indicators of Population Acuity

VCL monitors the percentage of contacts that result in dispatch of emergency services or facility transport plan (FTP). The former indicates that the caller or someone else was in imminent danger and unable to stay safe on their own, necessitating immediate intervention. An FTP is conducted when the risk to the caller or the person they are calling about is acute, but the individual can self-transport or be transported by a trusted other.

Key Performance Indicator	Definition	Current Status	Target
Total Emergency Dispatch Requests Initiated	Number of calls handled resulting in dispatch of emergency services	Reviewed and reported monthly	No target
Total Facility Transport Plans (FTP) Initiated	Number of calls handled resulting in a facility transportation plan (FTP) for urgent care	Reviewed and reported monthly	No target
Referrals (Consults)	Total Number of Referrals to SPCs	Reviewed and reported monthly	No target

Customer Satisfaction

Another key measure of meeting Veteran needs comes directly from the Veteran themselves. Call responders know firsthand the difference made for Veterans through the work accomplished on the VCL. However, the VCL needed to quantify the construct for continued quality improvement and external stakeholder awareness. The VCL created the End of Call Satisfaction Question, primarily designed to record the level of a satisfaction a Caller reports.

To assess customer satisfaction, VCL phone responders ask near the end of the call: "If you were in crisis, would you call VCL again?" Originally this measure was reviewed only for Veteran callers; VCL added a metric to review satisfaction of third-party callers as well, since they are also part of VCL's population of service. For FY2018, over 95% of those that responded to the survey question stated they would call the VCL again for help.

Key Performance Indicator	Definition	Current Status	Target
Customer Satisfaction – Veteran/Service Member	Percentage of Callers with Yes response to following question at end of call, "If you were in crisis, would you call VCL again?" Denominator for the measure is defined as total answered calls where caller is identified as	Currently meeting target; Reviewed and reported monthly	95%

	a Veteran and at the conclusion of the call, a Routine consult is generated. Denominator will be discounted for calls where the caller: 1) refused to answer, 2) terminated the call, OR 3) asking the question was not clinically appropriate.		
Customer Satisfaction – 3 rd party	Percentage of Callers who called out of concern for a Veteran or Service Member with Yes response to following question at end of call, "If you were in crisis, would you call VCL again?" Denominator is the same as above.	Currently meeting target; Reviewed and reported monthly	95%

Quality of Phone Services Provided

VCL enhanced quality monitoring of phone calls with the implementation of a dedicated team of staff who monitor calls around the clock. Calls are assessed for use of listening skills, complete and thorough lethality assessment, degree of collaborative problem-solving, and resources or referral provided. In the rare circumstance that the responder did not adequately assist in mitigating identified risk, that call is rated “Unsuccessful” overall; the responder receives off-line retraining and must successfully pass monitors of 3 crisis-related calls before returning to independent practice. Eight monitored items are designated as critical for the success of a call. If any of these items are rated unsuccessful, the entire monitor is scored “Opportunities for Improvement.” There are 25 non-critical items, including items rating adherence to documentation standards; if 5 or more non-critical items are missed, the monitor is rated “Opportunities for Improvement,” even in the absence of missed critical items. This method of scoring statistically inflates the rate of monitors with “Opportunities for Improvement,” however; the critical nature of crisis prevention and intervention service demands excellence.

Key Performance Indicator	Definition	Current Status	Target
Silent Monitoring (Calls)	Percent of monitored calls that meet silent monitoring expectations to reduce suicidal risk to the caller	Currently meeting target; Reviewed and reported monthly	99%

Complaint Tracking

VCL tracks complaints via an email template submitted by any VCL staff member who learns of a complaint about VCL services.

Key Performance Indicator	Definition	Current Status	Target
---------------------------	------------	----------------	--------

Service Complaints	Number of complaints determined to be founded after investigation that relate to provision of quality service by VCL staff	Currently meeting target, Reviewed and reported monthly	10 or less
Technology Complaints	Number of complaints determined to be founded after investigation that relate to errors in phone routing, inability to access service, wait time, etc.	Currently meeting target; Reviewed and reported monthly	10 or less

Access to Services

VCL has partnered with local VA Office of Information and Technology (OI&T) staff to conduct testing of access to VCL services: phone, online chat, and text. OI&T staff conduct tests around the clock and record any difficulties experienced on a standardized tracking sheet.

Key Performance Indicator	Definition	Current Status	Target
Line Testing – Phone	Percent of tests on the Phone Product Line that were successful. (Successful Tests/Total Tests)	Currently meeting target, Reviewed and reported monthly	100%
Line Testing – Text	Percent of tests on the Text Product Line that were successful. (Successful Tests/Total Tests)	Currently meeting target, Reviewed and reported monthly	100%
Line Testing – Chat	Percent of tests on the Chat Product Line that were successful. (Successful Tests/Total Tests)	Currently meeting target, Reviewed and reported monthly	100%

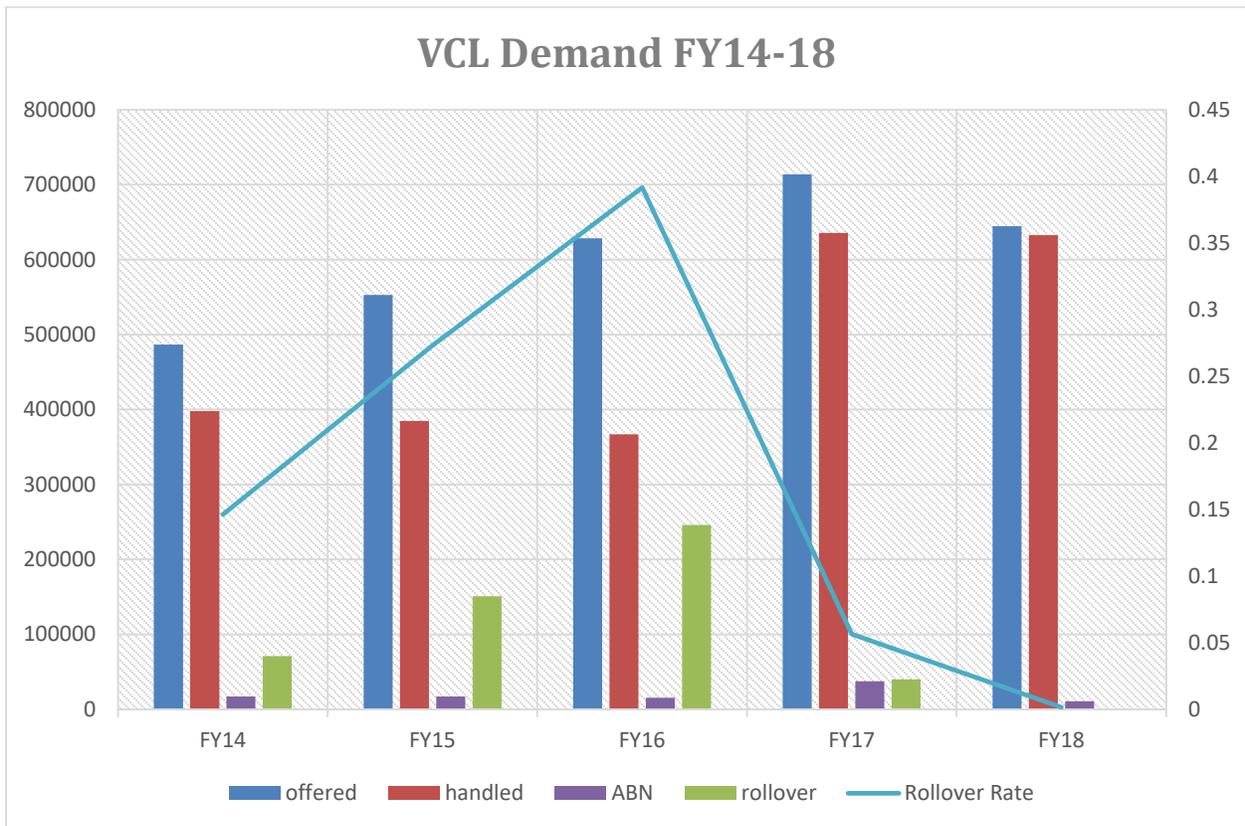
VCL’s Ability to Respond to Veterans

Since the 2016 expansion of the VCL crisis call centers, the VCL’s ability to respond to demand has significantly increased. Calls are no longer routinely routed to the contracted back-up center due to inability to respond. In fact, the rollover rate went from 39.16% of calls offered in FY2016 to 0.16% of calls offered in FY2018. This is significant as the FY call volume to the VCL has increased since 2016. For additional reference, a five year comparison was included (Figure A) to demonstrate select demand and performance outcomes. Focusing on FY2018, several of the critical metrics that define the VCL’s ability to respond to the needs of Veterans are as follows:

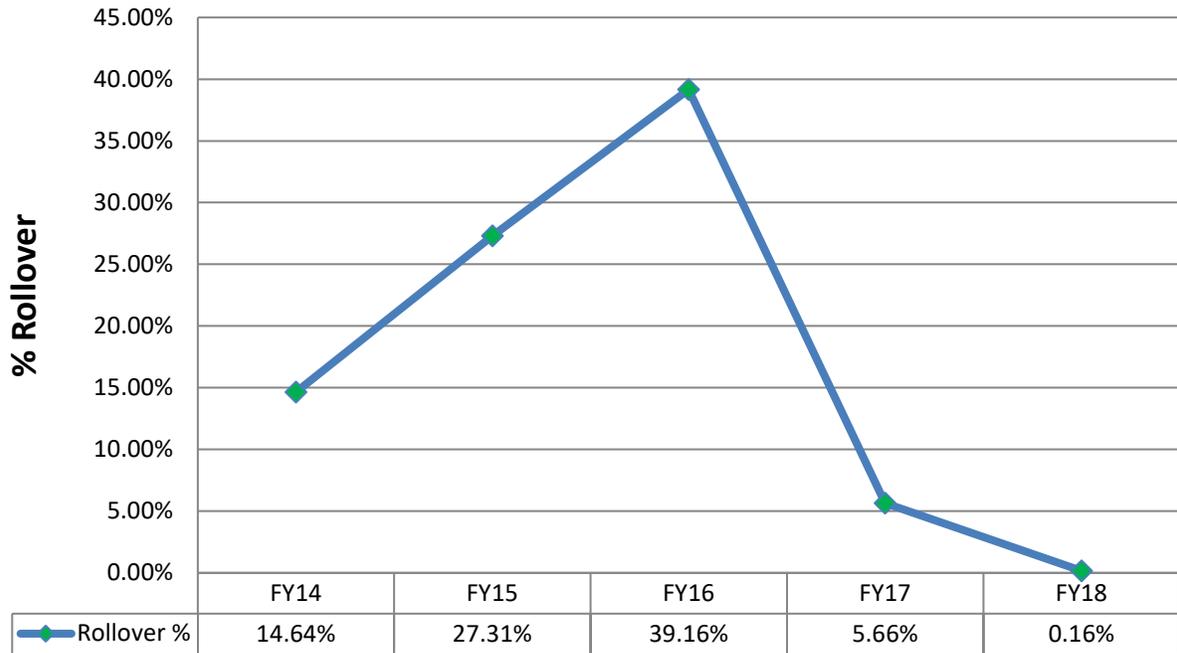
- 1) Amount of incoming offered calls to the VCL- 644,684
- 2) Amount of incoming calls answered by VCL- 632,682
- 3) The service level (calls answered within 20 seconds vs calls offered)- 98.05%

- 4) The abandonment percentage (ABN)- (amount of calls that disconnected >5 seconds before being responded to)- 1.70%
- 5) Total rollover calls to the backup center- 1056
- 6) Rollover rate vs calls offered- 0.16%
- 7) Average speed to answer- 8.22 seconds
- 8) The amount of referrals sent to a Suicide Prevention Coordinator- 116,033
- 9) The amount of requests for emergency dispatch of services where a caller was deemed to need immediate intervention- 29,252

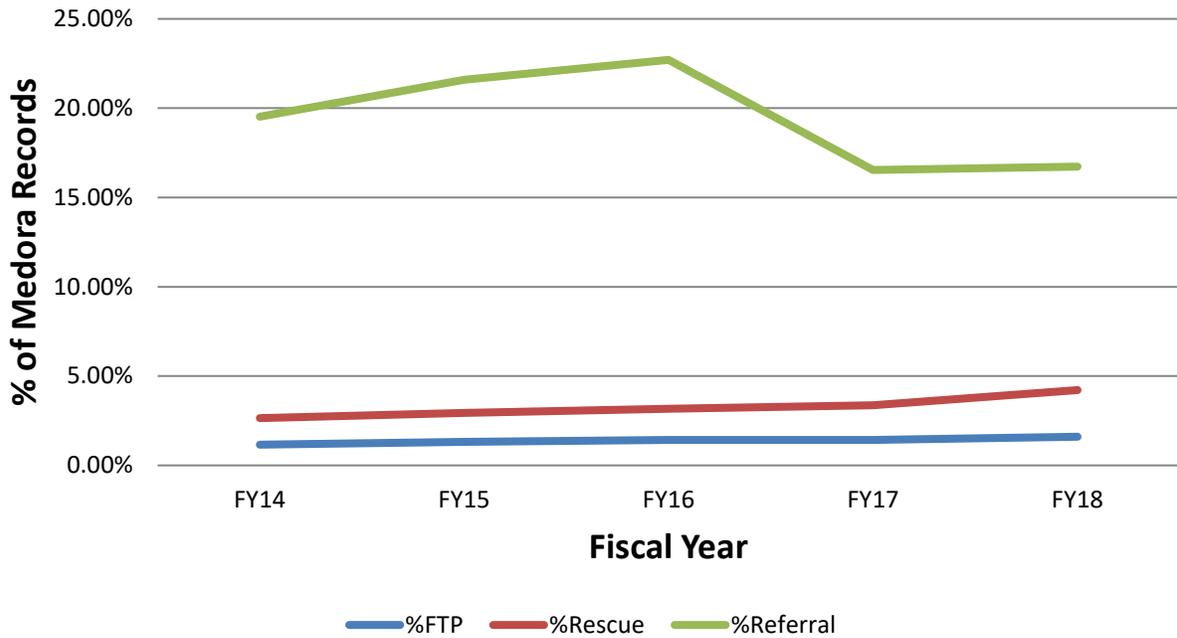
Figure A: 5 Year Comparison Charts



Rollover % By Fiscal Year



Trends by FY



Oversight and Accreditation

The VCL has received extensive internal and external review regarding policies, procedures and outcomes. Internally, these have come through the aforementioned Quality, Training, KPI, etc processes. VCL has also received review through the Office of the Inspector General (OIG), the Government Accountability Office (GAO) and through the accrediting bodies listed below (Figure B). VCL was successful in fully implementing corrective actions for seven OIG recommendations on Report No 14-03540-123 between February 2016 and July 2017. The VCL also fully implemented corrective actions for 16 OIG recommendations on Report No 16-03985-181 between March 2017 and March 2018. This resulted in a closure memorandum being issued for the report 14-03540-123 on August 16, 2017 and report 16-03985-181 on April 13, 2018. Recommendations focused on areas involving VCL operations, quality, and collaboration.

Figure B: Oversight and Accreditation



Community Outreach and Engagement

In order to meet the needs of Veterans, the VCL conducts outreach into the community through several different methods. These include regular outreach events conducted by field-based Suicide Prevention Coordinators and by VCL staff members. Last year alone, VA's Suicide Prevention Coordinators participated in over 20,000 outreach events reaching approximately 2 million individuals. At all of these events VCL contact information was provided through written materials as well as promotional items (cards, bracelets, bandanas, etc.). Many of these events also included training for community members in Operation S.A.V.E training, a gatekeeper training in suicide prevention. In addition, VCL staff also participate in outreach events through the Speakers Bureau where they bring a similar message to that of SPC's to the communities surrounding the 3 Call Center sites. This enhanced education allows for both broad messaging of VCL services and individual interaction.

In addition to the outreach events, VA also actively promotes VCL through it's inclusion of VCL contact information on various VA websites and many public service media campaigns. VA has also expanded its suicide prevention work with many community partners who now promote VCL through inclusion of contact information on their own websites and promotional materials.

APPENDIX C
THE NORTH AMERICAN NUMBERING COUNCIL (NANC) REPORT

North American Numbering Council

**Report and Recommendation on the
Feasibility of Establishing a 3-Digit Dialing Code
For a National Suicide Prevention and
Mental Health Crisis Hotline System**

May 10, 2019

Table of Contents

Section 1: Executive Summary.....	3
Section 2: Introduction and Background	4
Section 3: Assumptions.....	5
Section 4: Analysis of Alternatives.....	6
4.1: Common Attributes of N11 Codes	6
4.2: The 211 Code.....	7
4.3: The 311 Code.....	9
4.4: The 411 Code.....	10
4.5: The 511 Code.....	12
4.6: The 611 Code.....	13
4.7: The 711 Code.....	15
4.8: The 811 Code.....	16
4.9: The 911 Code.....	17
4.10: N11 Code Usage	20
4.11: N11 Code Analysis.....	21
4.12: A New Non-N11 3-Digit Dialing Code.....	25
4.13: A New Non-N11 3-Digit Dialing Code Using Number Sign (#) or Star (*)	26
4.14: Enhance Awareness of Existing Toll-Free Number(s)	28
Section 5: Implementation Logistics.....	29
5.1: Public Education Tasks	29
5.2: Service Provider Tasks.....	30
5.3: Additional Implementation Timeframe Considerations	33
Section 6: Implementation Costs.....	33
6.1: Service Provider Costs.....	33
6.2: States and Localities Costs	35
6.3: Federal Government Costs.....	35
6.4: Other Stakeholder Costs	36
Section 7: Recommendations	36
7.1: N11 Code Expansion.....	37
7.2: N11 Code Repurposing.....	39
7.3: New Non-N11 3-Digit Code	41
7.4: Other Considerations	44
7.5: Overall Recommendation	44
Section 8: Cost/Benefit Analysis	44
Appendix A: NAOWG March 7, 2019 Data Request to Service Provider Associations.....	46
Appendix B: March 13, 2019 NANPA Response per Second Referral Letter.....	47
Appendix C: March 19, 2019 Veterans Crisis Line (VCL) Response to NAOWG N11 Inquiry	48
Appendix D: April 2, 2019 Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) Response to NAOWG N11 Inquiry	57
Appendix E: March 2019 AIRS Survey of Blended Information and Referral/Crisis Members	60

Section 1: Executive Summary

The FCC tasked the North American Numbering Council (NANC) with developing a report and recommendation on the feasibility of establishing a 3-digit dialing code for a national suicide prevention and mental health crisis hotline system, whether such a 3-digit code should be established, and what 3-digit code should be established if such a code is established. The eight N11 codes are the scarcest resource in the North American Numbering Plan (NANP) and all eight N11 codes are in use today, whether officially designated for such use or not. The undesignated 411 and 611 codes are extensively used, and the designated codes (*i.e.*, 211, 311, 511, 711, 811, and 911) are used and relied on by many stakeholders in many or all jurisdictions throughout the country.

Only two of the eight N11 dialing codes share some common purpose with crisis and suicide hotlines: 211 and 911. The 211 code is already in use for crisis calling in some United States (U.S.) markets, relevant training and certification processes already exist for organizations that supply 211 services, today's 211 Interactive Voice Response (IVR) system capabilities can expand to route veteran and service member calls to the Veteran's Crisis Line (VCL) on a priority basis, and expanded use of 211 for suicide prevention calling has been cited as beneficial to promotional messaging for 211 overall.¹ Further, 211 services are already offered to 94% of the population today, so service providers are well-versed in routing calls to 211.²

Documented crisis and suicide call volume projections from the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA)³ and the Secretary of Veterans Affairs (VA)⁴ exceed levels for which 911 can reasonably be expected to accommodate an expanded use for both emergency calls and a national suicide prevention and mental health crisis hotline system. The use of IVRs on 911 calls would not be practicable, and the institutionalization of 911 for emergency calling eliminates its consideration for repurposing.

No other N11 dialing code reasonably meets key criteria (*e.g.*, call volumes, disruption to existing services, costs to transition existing uses to other alternatives) determined by the NANC to necessitate consideration for repurposing or expanded use with a national suicide prevention and mental health crisis hotline system.

For these reasons and those cited in this report, the NANC recommends:

- If a 3-digit code is to be established, the 211 code should be expanded to include crisis and suicide prevention calling services for veterans, service members, and civilian members of the U.S. population. The NANC recommends concurrent use of the existing toll free numbers (*e.g.*, 800-273-TALK, 800-SUICIDE) that have been institutionalized through traditional promotion and wide-scale use, at least until such time that their call volumes significantly diminish.
- If the 211 code is not expanded, then alternatively, the "988" non-N11 code should be deployed for a national suicide prevention and mental health crisis hotline system, as long as it is understood that 988 likely cannot be deployed ubiquitously across all networks, and mandatory 10-digit dialing may need to be implemented in area codes where 988 is assigned as a central office code in area codes where 7-digit local dialing is the norm.
- No N11 code should be repurposed for a national suicide prevention and mental health crisis hotline system, but the FCC should consider a periodic review of current uses of all N11 codes. Technological

¹ According to March 15, 2019 email discussions with Alliance of Information & Referral Systems (AIRS) representatives.

² See <http://www.211.org/pages/about>.

³ See April 2, 2019 Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) Response to NAOWG N11 Inquiry, in Appendix D.

⁴ See March 19, 2019 Veterans Crisis Line (VCL) Response to NAOWG N11 Inquiry, in Appendix C.

advances may eventually make some N11 codes' current designations moot and suitable for repurposing in the future, after an appropriate "idle" period. However, if the 211 code is not expanded and an N11 code must be repurposed, then the NANC recommends repurposing 511 because 511 service is not ubiquitously deployed, has many alternatives to obtain such information, and may be the most expeditiously repurposed with the least impact to users. The 511 code has among the fewest calls in the call volume data collected, and fewer societal, legislative and regulatory impacts.

Finally, the NANC recommends that the FCC issue a request for comments on its report before providing it to Congress, and a Notice of Proposed Rulemaking before any final order establishing any 3-digit dialing code (N11 or otherwise).

Section 2: Introduction and Background

On August 14, 2018, the National Suicide Hotline Improvement Act of 2018 (NSHIA)⁵ was signed into law. The NSHIA directs the FCC, to 1) conduct a study that examines the feasibility of designating a simple, easy-to-remember, 3-digit dialing code to be used for a national suicide prevention and mental health crisis hotline system; and 2) analyze how well the current National Suicide Prevention Lifeline (NSPL) is working to address the needs of veterans. The NSHIA directs the FCC to coordinate with the SAMHSA and the VA, as well as the NANC. Under the NSHIA, the SAMHSA and the VA must conduct studies and provide reports to the FCC by February 11, 2019. The FCC must then review that information, together with the information from its own study and consultation with the NANC, to produce a report by August 14, 2019. The FCC's report must recommend whether a particular N11 dialing code or dialing code covered by the NSHIA should be used for a national suicide prevention and mental health crisis hotline system, and if so, the logistics and costs associated with such a designation.

On November 8, 2018, the FCC directed the NANC, through its Numbering Administration Oversight Working Group (NAOWG), to:

- Consider the feasibility of using each of the currently-designated 3-digit dialing codes to be used for a national suicide prevention and mental health crisis hotline system, including codes the FCC has established for other purposes;
- Consider the feasibility of using a new easy-to-remember, 3-digit dialing code for such a system, including, for example, digits preceded by a star or number sign;
- Outline the logistics of using a currently-designated or newly-designated 3-digit dialing code, including but not limited to the need for translations changes in the network and cell site analysis and reprogramming by wireless carriers;
- Estimate the costs associated with using a currently-designated or newly-designated dialing code, including costs incurred by service providers to carry out the above logistics, and any costs the federal government, states and localities may incur to implement the dialing code;
- Recommend whether the FCC should designate a 3-digit dialing code for a national suicide prevention and mental health crisis hotline system and, if so, what 3-digit code it should designate;
- Provide a proposed cost-benefit analysis comparing use of a 3-digit dialing code with the current use of a toll-free number to operate the National Suicide Prevention Lifeline; and
- Provide any additional recommendations on the topic to assist the FCC with its report.⁶

⁵ See the National Suicide Hotline Improvement Act of 2018, signed into law on August 14, 2018:

<https://www.govtrack.us/congress/bills/115/hr2345/text>.

⁶ See November 8, 2018 letter from FCC Wireline Competition Bureau Chief Kris Anne Monteith to NANC Chairman Travis Kavulla:

<https://ecfsapi.fcc.gov/file/1108161310842/DOC-355003A1.pdf>.

On February 22, 2019, the FCC further directed the NANC, through its NAOWG, to address the following additional questions:

- If the FCC were to determine that adopting a 3-digit dialing code for a suicide prevention and mental health crisis hotline system is warranted, what N11 code or non-N11 3-digit code would the NANC recommend, and why?
- If the NANC recommends designating a new code that does not use a number sign or star (*e.g.*, 999) we direct the NANC to consult with the North American Numbering Plan Administrator to determine 1) if there is a specific code or codes best suited for this purpose, and 2) the impact of using that code or codes on NANP exhaust.
- If the NANC were to recommend repurposing an existing N11 dialing code, which of the existing codes would it recommend be repurposed, and why? Please obtain and analyze call volume/utilization data for the recommended code, compared to other codes, from as large a service provider sample as possible.
- If the NANC were to recommend an existing N11 code, which of the existing codes would it recommend for expansion, and why?
- Among the above three options, which would the NANC recommend?
- Finally, for the 3-digit code you recommend for a national suicide prevention and mental health crisis hotline system, please explain in detail the steps required to implement use of that code and an estimated timeline for implementation. Include in this explanation an analysis of the costs to implement the code for service providers, states and localities, and the Federal government. Please also use the attached reports from the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration and the Department of Veterans Affairs' Veterans Health Administration for any information relevant to your cost analysis.⁷

Following is the NANC's report to fulfill the above requests.

Section 3: Assumptions

The NANC made the following assumptions to establish a framework for its evaluation:

- Ideally any 3-digit code designated, whether an N11 code or a newly-designated code, should have ubiquitous reachability, *i.e.*, it can be dialed the same from any type of phone, whether wireline, wireless or Voice over Internet Protocol (VoIP).
- Any 3-digit code designated, whether an N11 code or a newly-designated code, will not start with a "0" or "1", because those are used for switching and routing purposes, and would require costly network upgrades for service providers.
- Any 3-digit code designated, whether an N11 code or a newly-designated code, may be reached at no charge to the caller, like the existing toll-free numbers for the National Suicide Prevention Lifeline are today.
- Any 3-digit code designated, whether an N11 code or a newly-designated code, will be routed the same as calls to the existing toll-free numbers for the National Suicide Prevention Lifeline are routed today.

⁷ See February 22, 2019 letter from FCC Wireline Competition Bureau Chief Kris Anne Monteith to NANC Chairman Travis Kavulla: <https://ecfsapi.fcc.gov/file/1022286300496/NSHIA%20nd%20NANC%20Referral%20Letter%20%2022%202019.pdf>.

- Any newly-designated non-N11 code cannot correspond to an already assigned area code (e.g., 202 cannot be designated as a new 3-digit code because the 202 area code is already assigned and in use).⁸

Section 4: Analysis of Alternatives

The NANC analyzed four possible sets of alternatives for a 3-digit dialing code to be used for a national suicide prevention and mental health crisis hotline system: 1) the repurposing of or expanding use of each of the existing N11 codes; 2) a newly-designated non-N11 3-digit dialing code; 3) a newly-designated non-N11 3-digit dialing code using Number Sign (#) or Star (*); and 4) enhancing awareness of the existing toll-free numbers that provide access to suicide prevention and mental health crisis hotlines today.

4.1: Common Attributes of N11 Codes

The eight N11 codes are the scarcest resource in the NANP, and all eight codes are in use today, either through regulatory designation or generally accepted use.⁹ As such, there are common attributes, advantages and disadvantages that apply to all N11 codes when considering them for use to reach a national suicide prevention and mental health crisis hotline system:

- An advantage is that the N11 architecture is an established abbreviated dialing plan, recognized by both switch manufacturers and the public at large.
- Expanded or shared use has been considered in past regulatory proceedings, but was rejected since shared use could cause caller confusion and reduce the effectiveness of the designation.¹⁰
- A disadvantage is that the use of each N11 code is well-known by the public already, making it difficult if not impossible to “scrub” references of existing uses from the internet, phone books, hotel and other public phones, billboards and advertising, brochures, and other resources to ensure that information publicly available is accurate.
- A disadvantage is that because each N11 code is already in use today, repurposing or expanding any N11 code’s use for a national suicide prevention and mental health crisis hotline system would significantly delay the availability of access to the hotline because a longer implementation timeframe would be necessary.
- A disadvantage is that repurposing of any N11 introduces the risk that the national suicide prevention and mental health crisis hotline may receive unrelated calls despite significant user education and public information dissemination efforts.
- Except for 211 and 911, the N11 codes’ current uses are completely unrelated to a national suicide prevention and mental health crisis hotline, so it seems illogical to consider expanding their uses to serve dual purposes. It would take significant time to determine how to implement an N11 code to serve a dual purpose, and put the necessary structures in place for the two unrelated purposes to coexist without either purpose delaying timely access to the other. Thus, from a practical perspective, expanding the use of most N11 codes is not feasible.

⁸ The current status of each area code may be found in NANPA’s NPA database:

https://www.nationalnanpa.com/nanp1/npa_report.csv.

⁹ All but 411 and 611 have been designated by the FCC. While 411 and 611 have not been officially designated for information services and customer service or repair, respectively, the FCC has recognized their existing uses in past regulatory proceedings and to date has allowed them to continue. See most recent discussion in FCC 05-59, adopted March 10, 2005:

<https://docs.fcc.gov/public/attachments/FCC-05-59A1.pdf>. Ironically, the 411 and 611 codes may be the N11 codes that are called most extensively (other than perhaps 911), making them the most difficult to repurpose or expand their use for a national suicide prevention and mental health crisis hotline system.

¹⁰ See ¶11 in FCC 05-59, adopted March 10, 2005: <https://docs.fcc.gov/public/attachments/FCC-05-59A1.pdf>, when 811 was designated for pipeline safety purposes.

- A disadvantage to repurposing the use of an existing N11 code is that resources must be directed to educating the public on the repurposing of an existing N11 code and how to obtain the service previously provided under said code.
- Except for 411 and 611, a disadvantage to repurposing or expanding the use of an existing N11 code is the possibility that state and/or local governments may need to initiate a proceeding for implementation purposes, which could lengthen the timeline for establishing a national suicide prevention and mental health crisis hotline system.

4.2: The 211 Code

4.2.1: Background on 211

In July 2000, the FCC established the 211 code to provide essential community services, including basic human needs resources, physical and mental health resources, work support, veteran services, natural disaster relief, access to services in non-English languages, support for elderly Americans or persons with disabilities, children and family support, and suicide prevention.¹¹ About 94% of Americans have access to 211, and calls are routed to local telephone companies or regional calling centers upon dialing.¹² About 70% of 211 centers are operated or funded by United Way, an organization dedicated to community building and services. In 2017, 211 supported over 13.4 million calls and almost one million texts, web chats, and emails.¹³ According to United Way Worldwide, about one million of those requests are related to suicide, mental health, or addiction.¹⁴ In 2017, 211 operators provided the most referrals regarding physical or mental health services in addition to housing, utilities, and employment assistance.¹⁵

Today, 211 is not ubiquitously deployed across networks, is not managed by a sole operator,¹⁶ and the services offered may not be consistent among operators. Some local United Way organizations provide suicide prevention assistance while others only may act as a referral to the National Suicide Prevention Hotline.¹⁷ However, in its comments the United Way of Tri-County, Massachusetts states, “All 211 specialists are trained to assess and triage a caller in a mental health or suicide crisis and address appropriately, whether by deescalating and counseling themselves (if trained to do so), or by keeping the caller calm while transferring them to a crisis service.”¹⁸

¹¹ See FCC 00-256, adopted July 21, 2000: https://apps.fcc.gov/edocs_public/attachmatch/FCC-00-256A1.pdf. For more information regarding services covered, see <https://www.fcc.gov/consumers/guides/dial-211-essential-community-service> and www.211.org.

¹² See <http://www.211.org/pages/about>.

¹³ See <http://www.211.org/pages/about>.

¹⁴ See December 10, 2018 letter from United Way Worldwide: https://ecfsapi.fcc.gov/file/1210324317288/UWW_SuicideHotlineAct_FCCComment_FINAL_12102018.pdf.

¹⁵ See <http://www.211.org/pages/about>.

¹⁶ Currently 211 is mainly managed by United Way, whereas the National Suicide Prevention Hotline is managed by V!brant Emotional Health, the National Association of State Mental Health Program Directors (NASMHPD), the National Council for Behavioral Health, and others. See <https://suicidepreventionlifeline.org/about/>.

¹⁷ 211 operators typically refer or transfer callers to existing hotlines, such as 1-800-273-TALK, 1-800-SUICIDE, or 1-888-628-9454 for Spanish speakers. See <https://suicidepreventionlifeline.org/>. See also <https://www.fcc.gov/consumers/guides/dial-211-essential-community-services> that references the availability of 1-888-SUICIDE, and the availability of 1-877-SUICIDA for Spanish speakers as well.

¹⁸ See December 7, 2018 letter from United Way of Tri-County, operator of Mass2-1-1: <https://ecfsapi.fcc.gov/file/121015580438/FCC%20Letter%20dec%207%202018.pdf>.

4.2.2: Advantages of Repurposing or Expanding Use of 211

There are no apparent advantages of repurposing 211 for a national suicide prevention and mental health crisis hotline system because the volume of services provided by 211 today would have to be transferred elsewhere, and 211 is already well known for its variety of services.

Expanding the use of 211 to include the national suicide prevention and mental health crisis hotline system could be beneficial as there is already some public knowledge of 211 ties to the suicide prevention hotlines and a general helpline. A simple Google search indicates that 211 is well advertised for community services and for suicide prevention assistance on the internet today. Several United Way regional commenters, such as Maine, North Carolina, Tri-County Massachusetts, and United Way Worldwide have described a correlation between individuals seeking suicide prevention services who also may require other social services supported by the local 211 operator.¹⁹ Allowing 211 operators to act as a first line of defense in suicide prevention calls might alleviate the pressure on 911 call takers and allow the caller to obtain assistance for other non-suicide related services in addition to mental health referrals. As previously stated, there are cases where suicide prevention related calls might be better handled by a 211 operator, and upon need, can be escalated to a 911 call taker who can quickly dispatch emergency services. It must be ensured that calls can be reliably and quickly passed onto the local 911 Public Safety Answering Point (PSAP) when needed.

Another advantage of expanding the use of 211 is that it may improve the NSPL's ability to route wireless calls to hotlines nearest the geographic location from where the wireless call originated. Per SAMSHA, wireless calls to 800-273-TALK are routed based on originating area code,²⁰ so if a caller with a New York telephone number originates a call to 800-273-TALK while roaming in California, then the call is routed to a hotline call center in New York.

4.2.3: Disadvantages of Repurposing or Expanding Use of 211

A significant disadvantage of repurposing 211 for a national suicide prevention and mental health crisis hotline system is that the large volume of services provided by 211 today would have to be transferred elsewhere, and 211 is already well known for those services.

Disadvantages of expanding the use of 211 for a national suicide prevention and mental health crisis hotline system include:

- A caller in crisis may have less timely access to an experienced counselor that can assist him as the initial call taker assesses the situation, as the caller will likely be required to navigate through an IVR system.
- Depending on the particular organization, individuals answering 211 calls may not have sufficient experience or training in handling a crisis call or transferring the call to a trained counselor.

¹⁹ See December 10, 2018 letter from United Ways of Maine:

https://ecfsapi.fcc.gov/file/121116216279/UWMaine_SuicidePreventionAct_2018_PublicComment%20FINAL.pdf; December 10, 2018 letter from United Way or North Carolina:

https://ecfsapi.fcc.gov/file/1210859414054/UWW_SuicideHotlineImprovement_FCCComment_12102018.pdf; December 7, 2018 letter from United Way of Tri-County, operator of Mass2-1-1:

<https://ecfsapi.fcc.gov/file/121015580438/FCC%20Letter%20dec%207%202018.pdf>; and December, 10, 2018 letter from United Way Worldwide: https://ecfsapi.fcc.gov/file/1210324317288/UWW_SuicideHotlineAct_FCCComment_FINAL_12102018.pdf.

²⁰ See SAMHSA response to question #2 in the April 2, 2019 SAMHSA Response to NAOWG N11 Inquiry, in Appendix D.

- Some mental health professionals submitted comments specifically noting opposition to expanding the use of 211 for a national suicide prevention and mental health crisis hotline system, advocating instead for a separate 3-digit dialing code to be established.²¹

4.2.4: Additional Considerations Regarding 211

To properly facilitate effective suicide prevention and mental health crisis assistance, 211 would require universal standards of service, operator qualification, and escalation procedures. Jerome Ferson, President of the United Way of Olmstead County, states “Our 211 receives calls that are better suited for 911, and our 911 partners often receive calls that we can best answer.”²² This comment is echoed in many of United Way’s local branches’ comments. Currently, 211 operators do not have access to emergency address information and cannot dispatch emergency services to a caller in need. If 211 is expanded to include a national suicide prevention and mental health crisis hotline system, it is imperative that proper training is given to all 211 operators on instructing callers needing immediate emergency attention to dial 911. Indeed, the Alliance of Information & Referral Systems (AIRS), can assist with ensuring quality standards, training and escalation procedures (see Section 4.11.2 below for more information about AIRS).

If 211 is expanded so that existing 211 organization keep all current responsibilities and expand their suicide prevention and mental health crisis services, an IVR system should be implemented to place priority on emergencies and those in suicidal crisis, and then options to reach other non-critical referral services. Because 211 covers many services, it would be imperative that calls received by those in crisis are connected to a trained operator expeditiously. Extensive public education will be needed to ensure community awareness of all new and/or existing resources.

4.3: The 311 Code

4.3.1: Background on 311

In February 1997, the FCC ordered Bellcore, as the NANP administrator, to assign 311 as a national code for access to non-emergency police and other government services.²³ It was further ordered that when a provider of telecommunications services received a request from an entity to use 311 for access to non-emergency police and other government services in a particular jurisdiction, the provider must ensure that, within six months of the request: (1) entities that were assigned 311 at the local level prior to the effective date of the Order had relinquished non-compliant uses; and (2) it had taken any steps necessary (for example reprogramming switch software) to complete 311 calls from its subscribers to a requesting 311 entity in its service area.

²¹ See December 10, 2018 letter from the National Association of State Mental Health Program Directors: <https://ecfsapi.fcc.gov/file/121082305071/Letter%20to%20FCC%20on%203-Digit%20Lifeline%20Number%20-%202012-10-18.pdf>; December 9, 2018 letter from the National Alliance on Mental Illness-New Hampshire: <https://ecfsapi.fcc.gov/file/1209577202336/lifeline%20n11.pdf>; and December 9, 2018 letter from the Idaho Suicide Prevention Hotline: <https://ecfsapi.fcc.gov/file/1211010921436/FCC%20filing%20comments%201218.pdf>.

²² See December 11, 2018 letter from United Way of Olmsted County (Minnesota): <https://ecfsapi.fcc.gov/file/121108873124/211%20Suicide%20Calls%20Public%20Comment%2012.11.2018.pdf>.

²³ See ¶ 84 of the Ordering Clause in FCC 97-51 adopted February 18, 1997: https://transition.fcc.gov/Bureaus/Common_Carrier/Orders/1997/fcc97051.pdf.

Today the 311 N11 code is used across many states and communities²⁴ in various types of non-emergency functions such as: code and housing violations, graffiti removal, illegal burning, non-working streetlamps or traffic lights, noise complaints, potholes, or public safety concerns.

4.3.2: Advantages of Repurposing or Expanding Use of 311

No advantages of either repurposing or expanding the use of 311 are readily evident. However, should a decision be made to repurpose the 311 code for suicide prevention, the FCC would have to issue an order to repurpose use of the 311 code for the suicide prevention hotline and determine where the non-emergency and other government services currently served by the 311 code would need to be assigned. If a decision were made to expand the use of the 311 code to include the suicide prevention hotline capability, then a determination will need to be made on how to implement and educate the consumers on accessing the suicide prevention hotline. The options of repurposing or expanding are possible but could require significant implementation work by service providers and entities currently utilizing the 311 code, and in educating the general public.

4.3.3: Disadvantages of Repurposing or Expanding Use of 311

Repurposing or expanding the use of the 311 code would take many years to implement. Following are some disadvantages of repurposing or expanding the 311 code for suicide prevention:

- With 311 being widely advertised on the internet for non-emergency and government services, repurposing 311 solely for suicide prevention would require an extensive “cleanup” of all websites, phone directories and other information outlets with another N11 code or number.
- If the use of the 311 code is repurposed, general public education would need to be extensive in re-educating consumers on using a newly assigned number for the services currently served by 311.
- If the use of the 311 code is expanded, then individuals in a suicide or crisis situation would need to be educated to call 311 instead of 211 or 911 or one of the toll-free numbers already in place today.
- If the use of the 311 code is expanded, there will likely be financial or budgetary impacts on the cities, municipalities and/or counties that fund 311 today.
- If the use of the 311 code is expanded, the general public must be educated about its expanded use and an IVR system will likely need to be implemented to appropriately direct callers.
- Network changes may be required for either repurposing or expanding the use of the 311 code.
- If the use of the 311 code is repurposed or expanded, contracts between service providers and the entities that provide 311 services will likely need to be renegotiated.

4.4: The 411 Code

4.4.1: Background on 411

Although not officially designated by the FCC,²⁵ 411 has been used to access local Directory Assistance since the 1930s in the largest U.S. cities, and has been available in many smaller markets since the 1960s. Callers dial 411 for fast, efficient, and accurate Directory Assistance service. 411 services may be provided at no cost to customers that qualify under the Americans with Disabilities Act. 411 has become so familiar in U.S. society that it is commonly used as slang for “Information” and can even be found in song lyrics.²⁶ Although the

²⁴ As of 2015, more than 200 cities around the U.S. have traditional 311 services, and another 220 cities, mostly smaller municipalities, use an application to provide some type of 311-style capability. See <https://www.citylab.com/city-makers-connections/311>.

²⁵ While 411 has not been officially designated for information services, the FCC has recognized its use in past regulatory proceedings and to date has allowed its use to continue. See most recent discussion in FCC 05-59.

²⁶ For examples, see <https://www.lyrics.com/lyrics/411>.

internet has largely become a main source for what Directory Assistance has historically provided, 411 usage is not insignificant. Long distance Directory Assistance service has typically been provided through the use of 1-area code-555-1212.

For telephone service provided by traditional local exchange carriers, the local carrier will determine how to handle 411, the chosen local toll (intra-LATA) carrier will determine how to handle 555-1212 calls for area codes within the LATA, and the chosen long distance carrier for inter-LATA calls will determine how to handle other (area code)-555-1212 calls. For service provided by cellular and VoIP carriers where the customer does not have a choice of local toll or long distance carriers, all calls may be handled the same way (*e.g.*, transferred to the same third party information provider).

4.4.2: Advantages of Repurposing or Expanding Use of 411

Advantages of repurposing 411 include the theory that more and more people are opting for finding the same information provided by Directory Assistance through the use of the internet. This trend has further increased as consumers' access to the internet has become available on their mobile devices, and some service providers charge a fee for calling Directory Assistance. In addition, there is an alternative to 411 through the use of the 10-digit option using 1-area code-555-1212. In fact, some service providers that have both local and long distance networks may route Directory Assistance calls to the same Directory Assistance platforms regardless of the abbreviated dialing of 411 or the 10-digit dialing of 1-area code-555-1212. Similarly, in VoIP and wireless networks, there likely is not a distinction between local and long distance networks when routing the abbreviated dialing of 411 or the 10-digit dialing of 1-area code-555-1212, so those calls may be routed to the same Directory Assistance platform.

The advantages of expanding the use of 411 to include access to a national suicide prevention and mental health crisis hotline system may be addressed through the training of Directory Assistance operators to transfer calls directly to a crisis hotline. In fact, Directory Assistance operators may already be providing Directory Assistance for callers to obtain information necessary to contact an appropriate crisis hotline.

4.4.3: Disadvantages of Expanding Use of 411

The disadvantages of expanding the use of 411 are that Directory Assistance is well known for the purpose it serves and expanding its function may be difficult due to its historic and primary function. Additionally, Directory Assistance platforms are often automated, and may frustrate callers in crisis. Moreover, other than redirecting callers to a crisis line through a transfer or providing directory information for a caller to contact a crisis line themselves, it is unlikely that the Directory Assistance operator would have the skills or the consistent demand that would make the operator an effective counselor.

4.4.4: Disadvantages of Repurposing Use of 411

The disadvantage of repurposing 411 can be found with the historic nature of 411 being in use since the 1930s. Additionally, the popular use that exists today to access Directory Assistance services would be difficult to change from what has become a cultural understanding of the use of 411. Other than 911, 411 is arguably most known for what it has historically provided and to change that cultural definition would take generations. Thus, if 411 is to be considered for repurposing, the aging of this particular N11 would need to be comparable to the generational understanding of its use. The 411 code should be considered for repurposing only upon determination that Directory Assistance service is no longer relevant.

4.5: The 511 Code

4.5.1: Background on 511

In July 2000, the FCC established the 511 code as a national code to be used for access to traveler information services.²⁷ At that time, the FCC encouraged the U.S. Department of Transportation to facilitate ubiquitous deployment of 511 for access to travel information services across the country.²⁸ Today, 511 is used as a special service for local information regarding state highway transportation and traffic in the United States (and Canada) for non-emergency services (road conditions). While 511 is not implemented ubiquitously throughout the United States, these services are available in many states.²⁹

4.5.2: Advantages of Repurposing or Expanding Use of 511

One advantage of repurposing the use of 511 is that technological advances, such as smartphone applications (where wireless coverage is available) and in-vehicle navigation systems, may be diminishing the need for access to traveler information services via 511. The public may often use apps, such as Google Maps and Waze, toll-free numbers, social media or websites, radio information and digital traffic signage to obtain real-time and location-specific information about road conditions and traffic. Further, some states restrict drivers to making only hands-free calls, and some jurisdictions restrict drivers from making any calls (including hands-free calls),³⁰ so the convenience of 3-digit code may have diminished or continue to diminish. Thus, it is possible that repurposing 511 for a national suicide prevention and mental health crisis hotline system may have less public impact than repurposing other N11 codes, particularly if an easy-to-remember toll-free number can be established instead. Further, in its July 2000 order, the FCC planned to examine and reassess the assignment of the 511 code five years after the effective date of the order, to determine whether to consider designating the 511 code for other uses or removing the exclusive assignment for travel information services.³¹ To the NANC's knowledge, such an examination and reassessment has not occurred, but could be part of a larger overall review of all N11 codes and their current uses.

There are no apparent advantages of expanding the use of 511 to include its current use and a national suicide prevention and mental health crisis hotline system, as the two uses are disparate and unrelated.

4.5.3: Disadvantages of Repurposing or Expanding Use of 511

The following are disadvantages of repurposing or expanding the use of 511 for a national suicide prevention and mental health crisis hotline:

- 511 is deployed in about 67% of states today,³² so repurposing or expanding its use would require extensive customer re-education, as well as network translations changes, website, and other information source updates.
- There would be costs to states/localities to remove or replace roadway signage where access to 511 is advertised, and could lengthen the timeline for implementation.

²⁷ See FCC 00-256, adopted July 21, 2000: https://apps.fcc.gov/edocs_public/attachmatch/FCC-00-256A1.pdf.

²⁸ See ¶15, FCC 00-256, adopted July 21, 2000: https://apps.fcc.gov/edocs_public/attachmatch/FCC-00-256A1.pdf.

²⁹ According to <https://www.dmv.org/travel/511.php>, 35 states currently participate in the 511 system, but 511 may not be available statewide within those states (e.g., Texas, California).

³⁰ For example, see <https://www.ghsa.org/state-laws/issues/Distracted-Driving> and <https://www.azcentral.com/story/news/local/glendale/2018/11/30/west-valley-cities-ban-handheld-phone-use-while-driving/2152632002/>.

³¹ See ¶16, FCC 00-256, adopted July 21, 2000: https://apps.fcc.gov/edocs_public/attachmatch/FCC-00-256A1.pdf.

³² According to <https://www.dmv.org/travel/511.php>, 35 states currently participate in the 511 system, but 511 may not be available statewide within those states (e.g., Texas, California).

- Some state departments of transportation may have entered into contracts to provide 511 services, so repurposing or expanding the use may require breaking a contract or deferring implementation until all contracts have expired.

4.6: The 611 Code

4.6.1: Background on 611

Although not officially designated by the FCC, the FCC has long recognized that 611 is widely used by many service providers (*e.g.*, wireline, wireless) to provide access to customer repair offices or customer service. While it was first introduced by incumbent local exchange carriers (ILECs), many competitive LECs (CLECs), cable providers and wireless providers have adopted its use.³³ In fact, many wireless providers work with a “clearinghouse” to transfer a roaming customer’s 611 call to the roaming customer’s own service provider.³⁴ Some local exchange carriers (LECs) now no longer support 611 but provide a recording instructing callers to dial their toll-free number instead. The use of 611 by service providers is often for any type of repair or customer service issue a customer may have, and is not limited to only voice issues or troubles. Customers may also call 611 if they are having texting, internet or television programming troubles or questions, and need to speak with a representative from their service provider. Some service providers using 611 may not readily advertise 611 availability on their websites, but customer-facing personnel may verbalize such availability when communicating with customers directly.

4.6.2: Expanding Use of 611

Expanding the use of 611 to include its current use and a national suicide prevention and mental health crisis hotline system is illogical, as the two uses are disparate and unrelated, and the efforts that would be necessary to allow the two uses to coexist could exceed any benefit realized.

4.6.3: Repurposing Use of 611

Before repurposing 611 from its current use to a national suicide prevention and mental health crisis hotline, the FCC should carefully consider the practical implications and the time it will take for the industry to discontinue the current use, educate customers on alternative ways to reach customer service or repair, make translations or programming changes, and implement the new use for a national suicide prevention and mental health crisis hotline. Further, a significant general public education effort about the new 611 use is critical to ensure the benefits of the repurposing efforts are 1) more beneficial than simply expanding current public service announcement efforts around the current availability of 1-800-273-TALK,³⁵ 1-800-SUICIDE,³⁶ and other toll-free hotlines³⁷, and 2) substantially exceed the costs of the repurposing efforts.

³³ To ensure that no facilities-based LEC gained an unfair advantage over its competitors, the FCC determined that all providers of telephone exchange service should be enabled to use the 611 and 811 codes for repair services and business office uses, and that by dialing those N11 numbers, customers should be able to reach their own carriers’ repair or business services. See ¶ 46, FCC 97-51, adopted February 18, 1997: https://transition.fcc.gov/Bureaus/Common_Carrier/Orders/1997/fcc97051.pdf.

³⁴ For example, see <https://www.rangerwireless.com/Home>.

³⁵ See <https://suicidepreventionlifeline.org/talk-to-someone-now/>.

³⁶ See <https://www.treatmentadvocacycenter.org/component/content/article/186-old-get-help/619-1-800-suicide-1-800-784-2433-hotline>.

³⁷ For example, the Suicide Prevention Lifeline offers help in Spanish via its 1-888-628-9454 toll-free number; see <https://suicidepreventionlifeline.org/help-yourself/en-espanol/>.

4.6.4: Advantages of Repurposing 611

The following are advantages of repurposing 611 for a national suicide prevention and mental health crisis hotline:

- Translations or programming changes to re-direct 611 calls to a single a toll-free crisis hotline may be less labor intensive than repurposing other N11 codes that are utilized on a more localized basis.
- Most service providers that use 611 today for customer service or repair likely have toll-free numbers where customers can reach them, as well as other avenues such as on-line chat and/or social media.
- Most service providers have various avenues to reach their customers to educate them about 611 being repurposed, through bill messages or bill inserts, text messages, website notifications, social media, etc.

4.6.5: Disadvantages of Repurposing 611

The following are disadvantages of repurposing 611 for a national suicide prevention and mental health crisis hotline:

- Repurposing 611 could take years to implement, as it would require significant and lengthy re-education and education efforts.
 - Customers would need to be educated to stop calling 611 for customer service or repair and directed to the appropriate number(s) to call instead.
 - The 611 code would need to sit idle for an extended period of time, to further educate customers that may still continue to call 611 for customer service or repair purposes after such use is discontinued. This would be critical to avoid the crisis hotline's trunking capacity resources from being tied up with callers trying to reach their service providers' customer service/repair centers and potentially delaying a crisis call from being answered.
 - The public-at-large would need to be educated about the new use for 611. Without an extensive public education program, the benefit of repurposing 611 will go unrealized.
- Service providers that support 611 for customer service or repair today would need to make extensive updates to their websites, internal materials, educate customer-facing personnel, etc.
- Service providers that support 611 for customer service or repair today would need to make all the necessary programming changes, twice – first to direct 611 calls to announcement, and then later direct those calls to the crisis hotline.
- Many payphones are operated by third party providers today, so those that support 611 for customer service or repair would need to be notified to update signage appropriately on all payphones, and be given time to make such updates.
- Third party clearinghouses that route wireless roamer calls to 611 would need to update call routing and other business processes, update contracts with service providers, etc.
- One commenter has suggested that the idle period could be as short as 3-6 months,³⁸ but that is too optimistic when considering: 1) that many service providers' processes to communicate notifications to customers could require a significant lead-time, 2) that the idle period will be a critical element in educating customers to stop calling 611 for customer service or repair purposes, and 3) that an extended and extensive general public education campaign is essential in ensuring that the crisis hotline is not deluged with unrelated calls.

³⁸ See December 5, 2018 letter from U.S. Department of Veterans Affairs:
<https://ecfsapi.fcc.gov/file/12050869520110/611%20Aging%20Process%20WC%2018-336%20CC%2092-105%20VA%20Hurlbert.pdf>.

- Some wireless service providers may preload 611 in the contact list in a customer's device so that customers have easy access to customer service or repair, so eliminating those could require significant efforts to correct existing uses and discontinue those practices going forward.

4.7: The 711 Code

4.7.1: Background on 711

On February 19, 1997, the FCC reserved for future implementation an abbreviated dialing code, 711, for more convenient and consistent access to telecommunications relay services (TRS). TRS is a telephone service that allows persons with hearing or speech disabilities to place or receive telephone calls. In July 2000, the FCC required the nationwide implementation of access to TRS for persons with hearing and speech disabilities via the abbreviated dialing code 711.³⁹ In May 2007, the FCC extended the disability access requirements under section 255 of the Communications Act of 1934, as amended in 1996, to providers of interconnected VoIP services.⁴⁰ Callers dialing 711 are routed to the contracted relay service provider.

The 711 code is not just for consumers with disabilities. Both voice and TRS users can initiate a call from any telephone, anywhere in the U.S., by dialing 711 without having to remember and dial a 7 or 10-digit number. When a person with a hearing or speech disability initiates a TRS call, the person uses a teletypewriter (TTY) or other text input device to call the TRS relay center, and gives a communications assistant the number of the party that he or she wants to call. The communications assistant places an outbound traditional voice call to that person and then serves as a link for the call, relaying the text of the calling party in voice to the called party, and converting to text what the called party voices back to the calling party.⁴¹ When a TRS user dials the 711 code, the telecommunications service provider automatically routes the call to the state-selected relay center. Relay service is provided by the TRS provider that charges a per-minute rate that is agreed upon through a state contract. Most state contracts require an annual budget to be used for customer outreach and marketing for relay services and equipment. TRS minutes using the 711 abbreviated code are decreasing due to new technology such as Real Time Text and services using internet protocol.⁴²

4.7.2: Advantages of Repurposing or Expanding Use of 711

There are no immediate advantages of repurposing or expanding the use of 711 for a national suicide prevention and mental health crisis hotline. Calls to 711 from payphones are free of charge to the caller,⁴³ but the availability and use of payphones is declining. However, as services are being transitioned to fiber and end users of analog TTY equipment and services transition to IP-based equipment and services, the need for traditional relay service may be eliminated eventually, and it's possible that 711 could be repurposed for another use then.

4.7.3: Disadvantages of Repurposing or Expanding Use of 711

The 711 abbreviated dialing code is widely used nationwide and is an unlikely candidate to be considered for repurposing or expanding its use, as it would be quite costly to do so. The FCC ordered the use of 711 for convenience and consistency to access relay services that persons with hearing or speech disabilities have become accustomed to. 711 is well established and has been advertised in media and publications by TRS

³⁹ See FCC 00-257, adopted July 21, 2000: <https://ecfsapi.fcc.gov/file/6511559470.pdf>.

⁴⁰ See FCC 07-110, adopted May 31, 2007: <https://ecfsapi.fcc.gov/file/6520014124.pdf>.

⁴¹ See <https://www.fcc.gov/consumers/guides/telecommunications-relay-service-trs>.

⁴² See ¶ 8 in FCC 18-79, adopted June 7, 2018: <https://docs.fcc.gov/public/attachments/FCC-18-79A1.pdf>. See also comments from the Disability Coalition for Technology Transition filed October 25, 2015: <https://ecfsapi.fcc.gov/file/60001331016.pdf>.

⁴³ See <http://www2.fcc.gov/cgb/consumerfacts/Payphones.pdf>.

providers and state agencies for over fifteen years. If 711 is repurposed, it would require a longer aging time, maybe three to five years, to account for any existing state contracts to expire. It is critical that the customer education plan include the appropriate communications so consumers with hearing loss, vision loss, or speech disabilities become aware of the repurposing, and are directed to stop calling 711 and redirected to the appropriate number. Translations and coding changes within the network would be required to redirect the 711 call to the new local or toll-free number for the new service.

It would be illogical to expand the use of the 711 code since the calls are answered by a communications assistant that comes with a per-minute rate paid by state agencies. If 711 is expanded to continue to be used for TRS relay services as well as the suicide hotline, an IVR system would need to be implemented so the caller would choose which services he wishes to utilize.

4.8: The 811 Code

4.8.1: Background on 811

For some time, states and localities have operated “One Call” numbers that contractors or property owners could call to identify underground utility locations and to avoid damage to these facilities when excavating. Many (though not all) of these numbers are toll-free and there is a national toll-free referral number that callers can dial to find the appropriate One Call number for their local area.

In 1999, the National Telecommunications Damage Prevention Council (NTDPC) concluded that there was, nonetheless, a need for an abbreviated, easily recognizable code for contacting the local One Call Center, particularly for mobile phone users and most notably contractors. The NTDPC selected #344 as the access code, and some wireless service providers implemented it. The Common Ground Alliance (CGA) was given the task of pursuing nationwide implementation of a toll-free pipeline safety number, and those efforts resulted in a legislative mandate. On December 17, 2002, the Pipeline Safety Improvement Act of 2002 was signed into law.

At its January 2003 meeting, the NANC established an Issues Management Group to examine alternatives and issues related to implementation of the mandate, and provided a report to the FCC on the topic in December 2003. In its report, the NANC recommended that the toll-free One Call abbreviated dialing number mandated by the Pipeline Safety Improvement Act of 2002 be implemented using an N11 code, specifically 811. The N11 architecture was an established abbreviated dialing plan, recognized by both switch manufacturers and the public at large, and 811 was the only N11 code not already in use.

The NANC recognized that the 811 solution depleted the quantity of remaining N11 codes, but 811 satisfied the legislative mandate that dialing be uniform across the entire nation. However, the NANC also noted in its report that absent the statutory requirement for a 3-digit code, many of the members would have recommended use of a single 10-digit toll-free number instead, noting that nationwide coverage could be implemented much more quickly and with less cost than a 3-digit alternative since existing numbers would not need to be vacated and switch development was not necessary.

In March 2005, the FCC established the 811 code as the nationwide code for the services that coordinate location services for underground public utilities.⁴⁴

⁴⁴ See FCC 05-59, adopted March 10, 2005: <https://docs.fcc.gov/public/attachments/FCC-05-59A1.pdf>.

4.8.2: Advantages of Repurposing or Expanding Use of 811

The FCC designated the use of 811 to access One Call Centers pursuant to the 2002 Pipeline Safety Improvement Act, which required a toll-free 3-digit code. However, the purpose of the current use of 811 for pipeline safety may be adequately fulfilled through an easy-to-remember 10-digit toll-free number, leaving 811 open to potentially be repurposed for a national suicide prevention and mental health crisis hotline.

4.8.3: Disadvantages of Repurposing or Expanding Use of 811

The following are disadvantages of repurposing or expanding the use of 811 for a national suicide prevention and mental health crisis hotline:

- 811 is the N11 code that has been most recently assigned to a nationwide use, and thus seems unlikely to be considered for reassignment for a national suicide prevention and mental health crisis hotline.
- Repurposing 811 for a national suicide prevention and mental health crisis hotline would take significant time and public education, including an adequate idle period to ensure callers are educated to stop calling 811 for pipeline safety purposes, and that an adequate extended and extensive public education campaign is implemented to ensure that the national suicide prevention and mental health crisis hotline is not deluged with unrelated calls.
- Expanding the use of 811 to include its current use and a national suicide prevention and mental health crisis hotline system is illogical, as the two uses are disparate and unrelated, and the efforts that would be necessary to allow the two uses to coexist could exceed any benefit realized.
- Any repurposing or expanded use of 811 would require legislative changes.

4.9: The 911 Code

4.9.1: Background on 911

In October 1999, the Wireless Communications and Public Safety Act of 1999 (“911 Act”) took effect with the purpose of improving public safety by encouraging and facilitating the prompt deployment of a nationwide, seamless communications infrastructure for emergency services. One provision of the 911 Act directed the FCC to make 911 the universal emergency number for all telephone services.⁴⁵ Subsequently, the FCC mandated that non-service-initialized wireless handsets (“non-initialized phones”) be capable of completing calls to 911, and that telephone number “123-456-7890” be reflected as the Calling Number in order to alert the PSAP when the calling phone has no call-back capability.⁴⁶ At least 98% of the U.S. population is served by PSAPs with Phase II capability for wireless location determination.⁴⁷ Further, 95% of the U.S. population has access to wireless telephone service⁴⁸ and household voice subscribership in the U.S. is over 96%.⁴⁹ State laws and regulations that govern 911 system funding vary by jurisdiction.

4.9.2: Advantages of Repurposing 911

No advantages of repurposing the use of 911 are evident, considering its wide availability today and the critical nature of its current use.

⁴⁵ See <https://www.fcc.gov/general/9-1-1-and-e9-1-1-services>.

⁴⁶ See FCC 02-120, adopted April 17, 2002: https://apps.fcc.gov/edocs_public/attachmatch/FCC-02-120A1.doc.

⁴⁷ See footnote 5 in FCC 17-125, adopted September 26, 2017: <https://ecfsapi.fcc.gov/file/09263029314893/FCC-17-125A1.pdf>.

⁴⁸ See <http://www.pewinternet.org/fact-sheet/mobile/>.

⁴⁹ See the FCC’s Universal Service Monitoring Report (data received through September 2017): https://www.fcc.gov/sites/default/files/2017_universal_service_monitoring_report.pdf and the FCC’s Voice Telephone Services: Status as of June 30, 2017 Report: <https://docs.fcc.gov/public/attachments/DOC-355165A1.pdf>.

4.9.3: Advantages of Expanding Use of 911

The following are advantages of expanding the use of 911 for a national suicide prevention and mental health crisis hotline:

- Calls to 911 already contain location and call-back information.
- Calls to 911 already go to the correct emergency responders who can immediately engage, when necessary, for the location.
- Calls to 911 from payphones are free of charge.⁵⁰
- Calls to 911 complete from mobile phones that are non-service-initialized.
- The mandated use of “123-456-7890” as the calling number from non-service-initialized mobile phones is potentially as useful to the call recipient in the crisis environment as it is in the emergency environment.
- Some training and experience of 911 call center personnel align with those necessary in suicidal crisis situations.
- The National Association of State 911 Administrators (“NASNA”), known as “the voice of the states on public policy issues impacting 911,” has stated on the record that “It is NASNA’s position that someone who is actively committing suicide should call 911.”⁵¹
- Some PSAPs already receive and transfer crisis calls to the NSPL.
- Avoids risk of number confusion to judgement-impaired crisis-callers.
- 24/7 nature of most 911 call centers.
- Service providers already support routing calls to 911, so technical implementation work may be minimal.
- The FCC, states, and local jurisdictions are highly engaged in the operations and funding of 911 services.⁵²
- The implementation of Kari’s Law,⁵³ in which calling to 911 is better assured from multi-line telephone system-equipped hotels and other facilities, provides a potential advantage to the expanded use of 911.

4.9.4: Disadvantages of Repurposing 911

The following are disadvantages of repurposing the use of 911 for a national suicide prevention and mental health crisis hotline:

- 911 is culturally associated with emergencies.
- Need for a very significant and potentially costly public education campaign.
- Technical transition costs would be significant.
- Very high risk to life and property during any transition of emergency services from 911 to some other code or number.
- Highway call boxes and similar public calling devices would need to be updated where they are programmed to call 911 call centers.
- Any repurposing of 911 would require legislative changes.

⁵⁰ See <http://www2.fcc.gov/cgb/consumerfacts/Payphones.pdf>.

⁵¹ See December 10, 2018 comments from the National Association of State 911 Administrators: <https://ecfsapi.fcc.gov/file/121194298110/Comments%20of%20NASNA%20-%20Implementing%20the%20National%20Suicide%20Hotline%20Act%20FINAL.pdf>.

⁵² For example, see the FCC’s Tenth Annual 911 Fee Report to Congress on State Collection and Distribution of 911 and Enhanced 911 Fees and Charges for 2017, dated December 17, 2018: <https://www.fcc.gov/file/14980/download>.

⁵³ See Kari’s Law Act of 2017, signed into law on February 16, 2018: <https://www.congress.gov/115/plaws/publ127/PLAW-115publ127.pdf>.

4.9.5: Disadvantages of Expanding Use of 911

The following are disadvantages of expanding the use of 911 for a national suicide prevention and mental health crisis hotline:

- Callers seeking suicide or mental health counseling could overwhelm some 911 call centers and/or the capacity of existing 911 circuits, necessitating continued reliance on crisis response services, requiring an ongoing level of consumer education, and requiring augmentation of 911 circuits.
- Some states redirect 911 funds to other programs,⁵⁴ which could further burden the provision of expanding 911 services.
- Some 911 call takers are expected to answer all calls within a certain timeframe⁵⁵ and some 911 calls average just 2 minutes or less,⁵⁶ so additional staffing, training and possibly workspace would be needed to accommodate the additional call volume and potentially extended call duration.
- Despite general public education efforts, there may be a possibility that callers in crisis will not call 911 for counseling because the thought that “911 is for emergencies only” is already ingrained, or because callers fear that their 911 calls will be recorded and made public.
- Any expansion of 911 would require legislative changes.

4.9.6: Additional Considerations Regarding 911

The following should be considered before expanding or repurposing the use of 911 for a national suicide prevention and mental health crisis hotline:

- Greater direct input from 911 call centers must be gathered before making any final determination to expand the use of 911. For example, liability concerns first must be addressed; 911 call takers perform incidental triage today, but may not have the authority or training to manage a reported mental health issue.
- Additional consumer education efforts may be necessary to prevent additional non-crisis calls to 911 call centers.

⁵⁴ For example, see the FCC’s Tenth Annual 911 Fee Report to Congress on State Collection and Distribution of 911 and Enhanced 911 Fees and Charges for 2017, dated December 17, 2018: <https://www.fcc.gov/file/14980/download>.

⁵⁵ For example, see page 8 in the NENA Call Answering Standard/Model Recommendation revised August 31, 2017: https://cdn.ymaws.com/www.nena.org/resource/resmgr/standards/NENA_56-005.1_Call_Answering.pdf, and also information on the National Fire Protection Association (NFPA) 1061 Standard, last updated in 2014: <https://iaedjournal.org/link-fire-chain/>.

⁵⁶ For example, see pages 38-39 in the PSAP Staffing Guidelines Report as commissioned by the NENA SWAT Operations Team dated August 2003: https://c.ymcdn.com/sites/www.nena.org/resource/collection/0ACCC545-208F-4185-BF27-FE2AF801B213/PSAP_Staffing_Report.pdf.

4.10: N11 Code Usage

In its second referral letter, the FCC asked the NANC to obtain and analyze call volume/utilization data from as large a service provider sample as possible. To address this, the NANC's NAOWG sent a data request⁵⁷ to the following service provider associations for assistance in collecting and aggregating call volume/utilization data for each of the N11 codes for the period December 1, 2018 through February 28, 2019 from their members: ACA,⁵⁸ CCA,⁵⁹ CTIA,⁶⁰ INCOMPAS,⁶¹ ITTA,⁶² NCTA,⁶³ NTCA,⁶⁴ USTelecom,⁶⁵ and the VON Coalition.⁶⁶ The various associations have members that provide wireline, wireless and VoIP services, and the members cover all ranges of service providers in terms of size. Under confidentiality protections, each association was asked to collect and aggregate such data from its members. Each association was asked to provide the aggregated data to the NAOWG co-chair, who then further aggregated the data received into the "industry-wide" totals noted below.

Although not statistically representative of the entire industry,⁶⁷ the results below represent data from approximately 34 service providers, which collectively appear to cover a large majority of customers across the U.S. These results may provide an insight as to what, if any, N11 codes could be repurposed or expanded based on usage alone. Based on the data provided, the rankings and percentages of the 151,931,892 total calls made from December 1, 2018 through February 28, 2019 are:

N11 Code	Total calls made December 1, 2018 through February 28, 2019	Percentage of those total calls
611	74,163,403	48.81%
911	43,974,408	28.94%
411	17,793,381	11.71%
311	6,405,646	4.22%
211	4,406,436	2.90%
511	3,398,581	2.24%
811	1,383,094	0.91%
711	406,943	0.27%
Total	151,931,892	100.0%

From the data above, it is apparent that all N11 codes are used today, some with significant call volumes, particularly if the above data is extrapolated to represent annual figures.

⁵⁷ See the NAOWG March 7, 2019 Data Request to Service Provider Associations in Appendix A.

⁵⁸ See the American Cable Association website (<http://www.americancable.org/>) for more information.

⁵⁹ See the Competitive Carriers Association website (<https://ccamobile.org/>) for more information.

⁶⁰ See the CTIA – Everything Wireless website (<https://www.ctia.org/>) for more information.

⁶¹ See the INCOMPAS website (<https://www.incompas.org/>) for more information.

⁶² See the ITTA – The Voice of America's Broadband Providers website (<http://www.itta.us/>) for more information.

⁶³ See the NCTA – The Internet & Television Association website (<https://www.ncta.com/>) for more information.

⁶⁴ See the NTCA – The Rural Broadband Association website (<https://www.ntca.org/>) for more information.

⁶⁵ See the US Telecom – The Broadband Association website (<https://www.ustelecom.org/>) for more information.

⁶⁶ See the VON Coalition website (<http://www.von.org/>) for more information.

⁶⁷ It is unrealistic to expect that every service provider operating in the United States would respond to the data request; not every service provider may belong to one of the eight associations contacted for assistance.

4.11: N11 Code Analysis

Following is the NANC's analysis in determining which N11 code should be expanded, if any, and which N11 code should be repurposed, if any.

4.11.1: N11 Code Expansion

For each of the N11 codes, the NANC analyzed their current uses, and the advantages and disadvantages of expanding each of them to include access to a suicide prevention and mental health crisis hotline system. Only 211 and 911 appear to have any sort of connection to such a system; the other N11 codes' uses are disparate and unrelated. Thus, the NANC narrowed its focus to 211 and 911 in determining which N11 code may be the best candidate for expansion.

Many of the conclusions of the NANC are appropriately data driven. Although certain key data received from the Veterans Health Administration/Veterans Crisis Line (VCL), SAMHSA, and other sources are not entirely comparable, valid conclusions can readily be drawn. For example, some of the call volume data that were provided are measured and reported on an "answered-call" basis, whereas other call volume data are reflected on an "offered" or "inbound" basis. Also, some datasets are not mutually-exclusive. For example, a material subset of calls that are directed to 800-273-TALK subsequently route to the VCL, and VCL calls make up a small percentage of calls to 211. Despite such dataset inconsistencies, the common trends uniformly demonstrate steady increases in call volumes that can be used to support the projections that were provided. Further, supplied data reflect that the rapid increase in the use of crisis text lines and chat lines in some areas has not materially slowed increases in crisis call volumes. And the United Kingdom's public deployment of its National Health Service (NHS) 3-digit dialing code (*i.e.*, 111) resulted in extremely "rapid growth to the service" call volumes.⁶⁸ The VCL's total 2019 projection is for ~700,000 answered calls, however, that number could increase to as many as 2.382 million under an N11 dialing arrangement,⁶⁹ and the annual estimate for total market in an N11 environment ranges between 11 and 18.5 million calls.⁷⁰ Such call volume levels would clearly inhibit the ability of 911 call takers and dispatchers to focus on their core mission of providing emergency services, and the volumes raise serious concerns about 24/7 staffing and funding as well as trunk, system, and other infrastructure capacities, all of which are already known problems in some regions. Any use of IVR systems in a 911 calling environment would be complicated by the fact that children and the elderly would not likely interact well with an IVR, and that individuals whose primary languages are other than English and Spanish rely on 911.

Additionally, the VCL reflects a belief that "many people who would have otherwise called a N11 for mental health crisis would not call 911 for help," and that this "would especially be true for our nation's veterans and military personnel needing mental health support".⁷¹ The VCL has further indicated that it receives many calls in which the callers specifically request that police not be involved. Such responses reflect a "perceived or real" risk that crisis calling could be impeded under an expanded-use 911 scenario.

Further, SAMHSA cites a concern that fewer de-escalations could occur under a shared-use 911 approach which potentially would result in more emergency room visits, and that warm transfers necessitated by the

⁶⁸ See Figure 1 in the England model response in item #1D in the March 19, 2019 Veterans Crisis Line (VCL) Response to NANC N11 Inquiry, in Appendix C.

⁶⁹ See the England model response in item #1d in the March 19, 2019 VCL Response to NAOWG N11 Inquiry, in Appendix C.

⁷⁰ See the England model response in item #1d in the March 19, 2019 VCL Response to NAOWG N11 Inquiry, in Appendix C.

⁷¹ See item #3 in the March 19, 2019 VCL Response to NAOWG N11 Inquiry, in Appendix C. Similarly, SAMHSA notes that those who do not want an ambulance or police dispatched might avoid calling. See SAMHSA response to question #2 in the April 2, 2019 SAMHSA Response to NAOWG N11 Inquiry, in Appendix D.

911 expanded-use model could result in greater call-abandonment.⁷² While the warm-transfer issue could arise with other dialing codes, it appears reasonable to assume that a more crisis-oriented and less emergency-oriented expanded/shared-use or dedicated dialing code would have fewer such warm-transfer calls. Such concerns and issues appear to outweigh any benefits of 911-grade geolocation information available in an expanded-use 911 scenario. With all of these factors considered, the NANC determined that expanded use of 911 to include a national suicide prevention and mental health crisis hotline system is not workable on multiple levels, and concluded that the expanded-use 911 approach should not receive further consideration.

The NANC then focused on the expansion of the 211 code to include access to a national suicide prevention and mental health crisis hotline system. The AIRS contacted the NAOWG on March 7, 2019, describing its work and offering its assistance.

AIRS is a non-profit professional association that has been integrally involved in 211 since its inception as the universal telephone number for information and referral services.⁷³ This involvement dates back at least as far as May 1998, when AIRS and various United Way entities filed a petition for nationwide assignment of an abbreviated dialing code for access to community information and referral services that led to the establishment of 211 for such purposes.⁷⁴ Since that time, AIRS has expanded to become the sole source for standards, accreditations and certifications for the community information and referral sector.⁷⁵ NAOWG members had several email discussions with representatives of AIRS during the development of this report. According to email discussions with AIRS on March 15, 2019, about 30% of NPSL agencies are currently AIRS members, and only about 6% of 211 providers in the U.S. and Canada are not AIRS members. Further, AIRS explained that all 211 organizations base their information and referral services around the AIRS standards, and AIRS standards are considered the basis for 211 information and referral for crisis calls, including those associated with crisis interventions.⁷⁶ AIRS' support of, and partnership with, United Way entities in 211 is seen as strong, with more than 70% of 211 currently being operated or funded by a United Way entity.⁷⁷

Also in those March 15, 2019 email discussions, AIRS indicated that 211 is uniquely positioned for crisis and suicide prevention calling services, and that 211 already answers many suicide prevention-related calls. AIRS representatives explained that 211 is the most compatible existing use, because about 25% of the NSPL call centers are also 211 providers. Further, based on its longstanding role with, and experience in, 211, AIRS stated that using 211 for suicide prevention and community information/referral is technically feasible.

In its role, AIRS and its various partners, including certain United Way entities, have engaged in 211 public awareness efforts for twenty years. AIRS representatives have highlighted that the promotion of a single line for suicide and other help is not a huge marketing challenge. In fact, AIRS has indicated that there is difficulty promoting existing 211 as a service that can help everyone with any kind of situation except a suicide ideation. In other words, in the context of publicizing 211, AIRS sees value in expanding the use of 211 to more widely include suicide prevention and additional mental health crisis calling.

⁷² See SAMHSA response to question #2 in the April 2, 2019 SAMHSA Response to NAOWG N11 Inquiry, in Appendix D.

⁷³ For example, see the United Way and AIRS five-year status report regarding the implementation of 211 as the universal telephone number for information and referral services filed December 19, 2005: <https://ecfsapi.fcc.gov/file/6518190732.pdf>.

⁷⁴ See FCC 00-256, adopted July 21, 2000: https://apps.fcc.gov/edocs_public/attachmatch/FCC-00-256A1.pdf.

⁷⁵ See <https://www.airs.org/i4a/pages/index.cfm?pageid=3285>.

⁷⁶ See www.airs.org/standards.

⁷⁷ See <http://www.211.org/pages/about>.

In its role with 211, AIRS members have developed extensive experience with IVR systems. In the March 15, 2019 email discussions, AIRS indicated that IVRs became more “commonplace for everyone” about fifteen years ago, and AIRS confirmed that IVRs are widely integrated into 211. AIRS surmised that any hotline would need, at a minimum, an English/Spanish IVR question to appropriate direct callers. This is currently the case of the majority of 211s, so it would seem that an IVR is already incorporated with presumably a negligible effect.

At the request of the NAOWG, AIRS surveyed its members.⁷⁸ 86% of the 37 respondents to the survey are also part of 211. 76% of the 37 respondents are part of the NSPL. 65% of the 37 respondents have calls answered by an IVR, versus 35% of the 37 respondents answer calls using only a live person. 52% of the 25 that responded to a related question believe that the use of IVRs has a positive impact, and 44% of the 25 that responded indicate that IVR use makes no discernable difference.

Based on AIRS responses and responses to the AIRS member survey, it is clear that relatively few 211 lines are answered with a live call taker. Rather, AIRS has indicated most crisis lines also have a message requesting that people contact 911 if their life or the life of someone with them, is in immediate danger. Nowhere in AIRS responses is there any indication of systemic or insurmountable obstacles being inherent in the use of IVRs for crisis and suicide callers.

The legislative framework associated with the VCL requires that the VCL remain a separate service.⁷⁹ For veteran and service member calls placed to 211, adherence to this requirement has traditionally been accomplished through forwarding of veteran and service member calls to the VCL. Nowhere within the data and responses provided by the SAMHSA or VA/VCL is there evidence that this could not, or should not, continue.

The VCL responses indicated a very limited use of IVRs for crisis and suicide calls from veterans and service members, and those are only on the SAMHSA, V!brant, and 211 side (VCL has indicated that it does not currently use an IVR).⁸⁰ In instances of IVR use, VCL gets Option 1 consistent with the legislative framework noted above. Potential risks associated with the use of complex IVR decision trees are reflected in the VCL’s response,⁸¹ however, these do not appear to be tied to the use of any particular 3-digit dialing code and appear to be avoidable through proper IVR decision-tree structuring with veteran and service member calls remaining as Option 1.

Although the VCL legislative framework does not appear to prohibit an expanded use application with 911, the ability to reduce the number of veterans waiting to receive help through a platform that is legislatively mandated and supported by the United States Government to respond to veterans, service members and their families in behavioral health crisis” could be impaired if the primary mission of the call taker and dispatcher is to address emergency services.⁸² This obstacle does not appear to exist with an expanded-use 211 application in which the IVR decision tree places the veteran and service member option up-front.

In the March 15, 2019 email discussions, AIRS pointed out that there is no controlling body for 211, and no national switching or standardized call-routing methodology. In other words, there is potentially an opportunity to rationalize 211 call routing and switching nationally in a way that would introduce efficiencies that are not currently achieved. This opportunity seems to traverse 211 provider operations and telephone

⁷⁸ See March 2019 AIRS Survey of Blended Information and Referral/Crisis Members, in Appendix E.

⁷⁹ See item #3 in the March 19, 2019 VCL Response to NAOWG N11 Inquiry, in Appendix C.

⁸⁰ See item #2a in the March 19, 2019 VCL Response to NAOWG N11 Inquiry, in Appendix C.

⁸¹ See item #2c in the March 19, 2019 VCL Response to NAOWG N11 Inquiry, in Appendix C.

⁸² See item #3 in the March 19, 2019 VCL Response to NAOWG N11 Inquiry, in Appendix C.

network providers for call routing. AIRS also referenced economies of scale that may be achievable through a broader expanded-use 211 suicide prevention and mental health crisis calling arrangement, which could mean reduced unit costs for 211 operations and for network providers (compared to existing arrangements in some areas, and compared to some other deployment options).

4.11.2: N11 Code Repurposing

For each of the N11 codes, the NANC analyzed their current uses, and the advantages and disadvantages of repurposing each of them for 3-digit access to a suicide prevention and mental health crisis hotline system. In formulating its recommendation, the NANC set certain criteria (*e.g.*, call volumes, disruption to existing services, costs to transition existing uses to other alternatives) for determining what N11 code would be a good choice for repurposing.

After review and analysis of each of the N11 codes, the NANC does not recommend repurposing an existing N11 code. Each N11 code provides a valued service and experiences significant use. Thus, there is no optimal N11 code to recommend for repurposing. Of the N11 codes, 511, 711 and 811 appear to experience the least overall use (see Section 4.10 above). Although the call volume for 711 is low in comparison to other N11 codes, the services provided by 711 are critical to those that use such TRS services. However, if TRS minutes continue to decrease due to new technology such as Real Time Text and services using internet protocol, then it is possible that 711 could eventually be repurposed for another use, after an appropriate idle period. Likewise, the call volume for the 811 code is low in comparison to other N11 codes, but the consequences of someone not calling before digging are severe; any consideration of repurposing the 811 code should only proceed with great caution.

However, the 511 code and the service it provides has many alternatives for the service and may be the most expeditiously repurposed with the least impact to users. Additionally, it has among the fewest calls in the call volume data collected in Section 4.10, and fewer societal, legislative and regulatory impacts. The NANC notes that the call volumes do not take into consideration the potential concentration of its availability and use primarily along the U.S. highway system. The 511 code appears to have the most alternatives associated with the service it provides, such as dedicated radio frequencies, on highway electronic signage, in-vehicle navigation and mobile internet access, as well as television coverage. While not deployed throughout all states, there are locations where the 511 code is heavily used and it would take some time for states to remove this signage before an appropriate idle period could start, so that eventually 511 could be used for other purposes.

There are concerns for any N11 code that may be chosen for repurposing. Although the 611 and 411 codes are not officially designated by the FCC for their current uses, the data in Section 4.10 above shows that there is significant demand for the services provided by those N11 codes. Similarly, with the 911 code receiving such a significant quantity of calls, it would be difficult to justify either repurposing or expanding the 911 code for a national suicide prevention and mental health crisis hotline system.

For some existing N11 codes, the volume of calls could become an issue for crisis line platform providers, even after a sufficient idle period. Today, there are hundreds of thousands of calls made daily to 411, and hundreds of thousands of calls made daily to 611 (*i.e.*, hundreds of millions of calls to each, annually). The impact of misdirected calls must be understood, before any of the N11 codes is repurposed. A crisis line platform provider will need to be aware of and have both the network and call taker resources to handle the amount of misdirected calls. For example, SAMHSA has indicated that it received 2,205,487 calls in 2018,⁸³ and of those

⁸³ See Figure 3 in the SAMHSA Report to the FCC filed Feb. 1, 2019: <https://ecfsapi.fcc.gov/file/1022280990575/19021504-1.pdf>.

calls the VA has indicated that it received 644,684 calls in FY2018⁸⁴. There is concern that the sheer volume of misdirected calls could overwhelm the platform and hamper the responsiveness, such that callers' lives could be placed in danger where call attempts may not go through due to platform network congestion or by call takers' time being consumed and delayed by handling misdirected calls.

For example, although SAMHSA has not promoted 1-800-SUICIDE since 2007, the NSPL still receives an average of 178,864 calls annually that are routed from 1-800-SUICIDE.⁸⁵ Thus, the call volume associated with 1-800-SUICIDE has experienced little decrease in use since it is no longer marketed as a resource. This raises some concern for the repurposing of any N11 code without significant aging, and the need for substantial public education to cease use of that N11 code.

The NANC recommends the FCC and associated stakeholders periodically monitor and evaluate the uses of N11 codes to assess if the N11 codes should eventually be repurposed as consumers transition into newer technologies. As discussed in the sections above, there needs to be some time for an N11 code to sit in an "idle" phase before that N11 code could be reissued and repurposed for another use. N11 codes are a finite resource and as such, their uses should be periodically reviewed for maximum utilization and a method established that would vacate current uses without being disruptive to current and new users of the N11 code.

Finally, if an N11 code must be repurposed, the NANC recommends that the 511 code because the service is not ubiquitously deployed, has many alternatives to obtain such information, and may be the most expeditiously repurposed with the least impact to users. Additionally, the 511 code has among the fewest calls in the call volume data collected in Section 4.10, and fewer societal, legislative and regulatory impacts. However, the NANC prefers its recommendation for expanding the 211 code as the most expedient and implementable three digit code solution.

4.12: A New Non-N11 3-Digit Dialing Code

4.12.1: Background on a New Non-N11 3-Digit Dialing Code

The FCC's referral letters also direct the NANC to consider designating a new easy-to-remember 3-digit dialing code that is not an N11 code (*e.g.*, 988), and to consult with the NANPA to determine 1) if there is a specific code or codes best suited for this purpose, and 2) the impact of using that code or codes on NANP exhaust. NANPA recommended the assignment of a 3-digit code that corresponds to an Easily Recognizable Code (ERC) (*i.e.*, area code), rather than a 3-digit code that corresponds to a General Purpose Code (GPC) area code.⁸⁶ NANPA indicated that using a GPC, although there is no evidence to show a large impact on NANP exhaust, would impact the availability of remaining geographic area codes and could set a precedent for using GPCs for services rather than relief of exhausting area codes.

There are advantages and disadvantages to establishing a new 3-digit code that is not an N11 code.

4.12.2: Advantages of Establishing a New Non-N11 3-Digit Dialing Code

The following are advantages of establishing a new, non-N11 3-digit dialing code (*e.g.*, 988) for a national suicide prevention and mental health crisis hotline:

⁸⁴ See page 11 and Figure A in the VA response to the FCC filed on Feb. 7, 2019:

<https://ecfsapi.fcc.gov/file/10222879923948/19021504-2.pdf>:

⁸⁵ See page 15 in the SAMHSA Report to the FCC filed Feb. 7, 2019: <https://ecfsapi.fcc.gov/file/1022280990575/19021504-1.pdf>.

⁸⁶ See NANPA's Mar. 13, 2019 response in Appendix B.

- Use of a new, wholly unique 3-digit code prevents the need to age an existing N11 code prior to repurposing. This should reduce the overall implementation timeline.⁸⁷
- Consumer education campaigns would be simplified compared to the repurposing or expanded use of an existing N11 code. Awareness campaigns of the new non-N11 3-digit code would be exclusively focused on the new suicide prevention and mental health crisis hotline and when to use it. A new, non-N11 3-digit code would expedite the rollout of a suicide prevention and mental health crisis hotline.
- A new non-N11 3-digit code should streamline the caller getting to dedicated personnel or experts expeditiously, whereas other solutions may require an IVR system to help guide the caller to the appropriate personnel.

4.12.3: Disadvantages of Establishing a New Non-N11 3-Digit Dialing Code

The following are disadvantages of establishing a new non-N11 3-digit dialing code (*e.g.*, 988) for a national suicide prevention and mental health crisis hotline:

- Requires the 3-digit code to correspond to an area code not already in service and that corresponding area code (*e.g.*, 988) to go unused, so 8 million 10-digit numbers cannot be assigned to customers. While one area code going unused is unlikely to materially affect NANP exhaust, the NANP is a finite resource and number conservation is a key tenet of FCC numbering oversight.
- Some wireline switches may be unable to support any new 3-digit dialing code that is not an N11 code.⁸⁸
- Where 7-digit dialing within the area code is still allowed⁸⁹, TDM wireline switches would need to implement a post dial delay or inter-digit timeout to distinguish between calls to the new non-N11 3-digit dialing code or calls to the corresponding central office code, if assigned.⁹⁰ Such a timeout could result in the caller terminating the call because he thinks the call failed, or unrelated calls being routed to the hotline when a 7-digit number is dialed too slowly. The post dial delay or inter-digit timeout would not be required if the 3-digit dialing code does not correspond to any assigned central office codes, or where mandatory 10-digit dialing already is implemented, assuming that the 3-digit code does not correspond to an area code already in service.
- If the selected non-N11 3-digit dialing code is already in use in any service providers' networks, then it would take some time for those service providers to educate their customers to discontinue that existing abbreviated dialing use and establish an alternative.

4.13: A New Non-N11 3-Digit Dialing Code Using Number Sign (#) or Star (*)

The FCC directed the NANC to investigate two possible alternatives for a 3-digit dialing code using a leading Number Sign (#) or Star (*) for access to a suicide prevention and mental health crisis hotline. These alternatives would be consistent with the legislative requirements, but are not necessarily technically feasible for all service providers.

⁸⁷ See December 10, 2018 comments from the Alliance for Telecommunications Industry Solutions' Industry Numbering Committee: [https://ecfsapi.fcc.gov/file/1210251168432/INC Comments on N11 Code - 121018.pdf](https://ecfsapi.fcc.gov/file/1210251168432/INC%20Comments%20on%20N11%20Code%20-%20121018.pdf).

⁸⁸ In the NANC's 2003 report and recommendation on an abbreviated dialing code for pipeline safety, the NANC identified a list of switches that would require development work to accommodate a non-N11 abbreviated dialing code, estimating that it would take 1-3 years for such work and implementation. See pages 8-9 of the report at http://www.nanc-chair.org/docs/nowg/Dec03_One-Call_Dig-IMG_Report.doc. It is reasonable to expect that in the last 15 years some of those switches no longer have any vendor support, and simply would have to be replaced.

⁸⁹ Approximately 161 area codes of 360 geographic area codes assigned and in service today allow 7-digit dialing (44.7%). See NANPA's NPA Dialing Plans report, last accessed 12/20/18: <https://www.nationalnanpa.com/enas/npaDialingPlansReport.do>.

⁹⁰ For example, if 999 was selected as the new 3-digit dialing code, then wireline switches serving the 202 area code (where 7-digit dialing is allowed) would need to implement an inter-digit timeout or post-dial delay to distinguish between calls to the suicide prevention and mental health crisis hotline and the assigned 202-999 central office code.

4.13.1: Background on Number Sign and Star

The values of NANP telephone numbers are the digits 0 through 9. Initially, individual digits were generated by the opening and closing of a relay in dial pulse telephones. In 1958, Bell Laboratories developed Dual Tone Multi-Frequency (DTMF) tones to generate numbers and to speed up connections. This became known as “Touch Tone[®]”⁹¹ and the characters # and * were added to push button phones. These characters now serve as network control characters. The dial equivalent to the Star (*) are the digits 1-1. There is no dialed equivalent to the Number Sign (#) character since it is not used in the dialing sequence, as is the Star.⁹²

4.13.2: Issues Surrounding the Use of the Number Sign (#)

The #XXX codes have not been defined in the NANP. Considerable network standards and development would be necessary to implement this type of dialing arrangement, but it is recognized that many wireless service providers have implemented such abbreviated dialing arrangements in their networks for particular purposes or customers. In addition, the # key is used as a network control character in some networks and those uses would need to be removed before any implementation could begin. Since the development of Touch Tone, the # key has been used to stop any switch timing and immediately process the call. In addition, the # key is used by Operator Services switching systems to re-originate a credit card call with the same billing information used in the preceding call. It is also used for control in connected systems, such as voice mail. The # is not a digit and only appears on DTMF phones.

In addition, due to the current lack of a universally-deployed, easily recognizable non-N11 3-digit code for use with a * or # character, any code to be considered would need to be determined to be generally available across service providers’ networks. Further, to the extent that a particular code is being used for abbreviated dialing by a service provider, eliminating these conflicts would require a dialing plan change in the service area, which would require customer notification and could cause considerable customer confusion and complaints as well as potential inadvertent calls to the national suicide prevention and mental health crisis hotline.

Wireless service providers today use # for carrier-specific abbreviated dialing for various applications. The use of # implemented by wireless service providers is not out of the ordinary, as wireless service providers typically have more control over customer equipment. Also, wireless switches have no need for post-dial delay or inter-digit timeouts to distinguish abbreviated dialing codes from standard 7- or 10-digit numbers since customers press a specific key (e.g., TALK, SEND or the “green” button) when finished dialing that signals to the switch the end of the dialing string.

4.13.3: Issues Surrounding the Use of Star (*)

Vertical Service Codes (e.g., *XX and *XXX) are a numbering resource maintained and administered by the North American Numbering Plan Administration (NANPA). The NANPA web site lists all assigned and reserved Vertical Service Codes (VSC).⁹³ The use of the Star as a prefix when dialing a VSC for call forwarding is in the form *XX. In this application, the Star indicates to the switching system that the digits following specify a certain desired feature/service from the switch. The industry has allowed the digits 1-1 to be used instead of

⁹¹ Touch Tone is a registered trademark of AT&T.

⁹² To minimize the amount of confusion experienced by callers using these characters, there is an effort to standardize their use. It is also important that consistent terminology be known and used when referring to these characters. The (#) and the (*) should be called the number sign and the star, respectively. Use of the terms asterisk for (*) and pound sign for (#) should not be used in documentation dealing with dialing procedures. The ITU has defined # and * as Number Sign and Star, respectively.

⁹³ See https://www.nationalnanpa.com/number_resource_info/vertical_service.html.

the Star when activating or deactivating a vertical service from a rotary phone. These codes are deleted by the switch from the call stream when used to activate or deactivate vertical services.

Other considerations that would complicate wireline use of a code using Star include:

- Some switch types are hard-coded to expect only 2 digits following the Star.
- Switches unequipped to provide custom calling features or vertical services may not be capable of processing access codes using Star. This would preclude these switches, and originating calls with codes using Star, from using this alternative.
- Not everyone (the public at large) knows that the 1-1 can be used instead of the Star when using a rotary dial phone.
- As with Number Sign, Star is used by some wireless service providers today for special applications (e.g., *611 for customer service).

4.13.4: Use of the Number Sign (#) or Star (*)

As detailed above, the use of access codes involving the Star or Number Sign is inconsistent with existing numbering plan definitions, and use of these characters would be difficult to implement in most wireline architectures. Therefore, the use of Number Sign and Star are not considered viable alternatives for access to a national suicide and mental health crisis hotline. The following summarizes the major issues (notwithstanding the above) with implementing either Number Sign or Star in the dialing sequence for wireline switches:

- Codes using Star or Number Sign would not achieve the uniformity desired since all users would not be dialing the same sequence. Rotary telephones do not include an alternative for Number Sign, and the workaround of dialing 1-1 for Star is not widely known by the public.
- Many PBX systems use Star and/or Number Sign for feature access. Reprogramming of these systems may not always be possible and could involve considerable customer expense and a lengthy deployment timeline.
- Some switching systems are not capable of dealing with Star and Number Sign in the dialing sequence and the necessary switch development, particularly on legacy systems slated for retirement, would both delay full implementation of the suicide prevention and mental health crisis hotline functionality as well as add considerable expense.

It may be assumed that the suicide prevention and mental health crisis hotline dialing sequence should be the same for all users, as the legislative mandate specifies investigation of the establishment of a 3-digit dialing code. However, there are ample precedents for dialing sets that differ by network type, and it is therefore conceivable that wireline and wireless implementations may differ, at least in use of Star (*) or Number Sign (#). For example, wireless users may dial 611 or *611 or #611 for repair, while wireline users can only dial 611 (where abbreviated dialing for customer service is available).

4.14: Enhance Awareness of Existing Toll-Free Number(s)

The FCC asked the NANC to recommend whether a new 3-digit code should be established, and if so, what the new 3-digit dialing code should be. There are no unused N11 codes available, and although a non-N11 3-digit dialing code may be implemented more easily than repurposing an N11 code, it is unlikely that a non-N11 3-digit dialing code can be implemented in all networks ubiquitously. The NSHIA requires the FCC to analyze how well the current NSPL is working to address the needs of veterans, and the SAMHSA and the VA reports submitted to the FCC in February 2019 provide information about the use of current toll-free numbers,

completion and treatment of calls to those numbers, and how they may be improved.⁹⁴ There is nothing in the record today that suggests that calls to the existing toll-free numbers have systemically failed to complete.

Section 5: Implementation Logistics

5.1: Public Education Tasks

Any change to the current use of an N11 code or the implementation of a new non-N11 3-digit abbreviated code dedicated to a national suicide prevention and mental health crisis hotline system will require a nationwide public education campaign by the FCC, state commissions, localities, and the relevant stakeholders, including the platform providers, the SAMHSA, the NSPL, the VA, etc.

5.1.1: Repurposing an N11 Code

If an existing N11 code were to be repurposed for a national suicide prevention and mental health crisis hotline system, extensive customer education and outreach efforts for both the current users and new users of the code would be required. Education efforts should include:

- Educate the general public, internal staff, and other stakeholders on the discontinuance of the current use associated with the N11 code.
- Educate the general public and internal staff on alternative ways to reach services previously provided under the N11 code (*e.g.*, for 611, a new number will be needed for repair and customer service calls).
- Educate the general public and internal staff on the new use of the N11 code.

To accommodate the repurposing of an N11 code, the timeline for the educational period and implementation of the new use could be expected to be lengthy, in order to be effective. For example, the 456 area code is the most recently reclaimed area code because its use over a 20-year period had steadily declined; it will be “aged” for at least five years before it is used for another purpose.⁹⁵ The 456 area code was used by service providers, so repurposing an N11 code heavily used today by end users would likely require an even longer “aging” period. In addition to other educational efforts, an idle period would be necessary to help educate callers, via an announcement, that the repurposed N11 code’s current use has been discontinued and an alternate number for the caller to use would have to be provided.

5.1.2: Expanding Use of an Existing N11 Code

As addressed above, the only N11 codes whose current use shares some commonality with a national suicide prevention and mental health crisis hotline system are 211 and 911, and thus no expansion of 311, 411, 511, 611, 711 or 811 was considered to be highly realistic. If the use of either the 211 or 911 code is expanded to include transfers to crisis hotline(s), then education and outreach efforts for both the current users and new users of that code would be required. Education efforts should include:

- Ensure that call takers are aware of likely increased call volumes for crisis call transfers to the crisis hotline(s).
- Post the expanded use of the N11 code on existing websites, materials, handouts, billboards, social media, etc.

⁹⁴ See the SAMHSA report to the FCC filed on February 1, 2019: <https://ecfsapi.fcc.gov/file/1022280990575/19021504-1.pdf> and the VA response to the FCC filed on February 7, 2019: <https://ecfsapi.fcc.gov/file/10222879923948/19021504-2.pdf>. See also the SAMHSA report to the NANC on March 28, 2019: <http://nanc-chair.org/docs/FCCPresentation3.28.19V3.pptx> and the VA report to the NANC on March 28, 2019: <http://nanc-chair.org/docs/VCLOverview-N11Briefing032819.pptx>.

⁹⁵ For example, see information about the 456 area code (aka NPA) at https://www.nationalnanpa.com/number_resource_info/456_codes.html.

- Educate the general public to call the designated N11 code for a suicide or crisis situation in addition to the N11 code's current uses.

5.1.3: Implementation of a New Non-N11 3-Digit Dialing Code

The introduction of a new non-N11 3-digit dialing code will require nationwide public notice of the new code, the code's purpose, and the implementation date. Because no current users would need to be re-educated, the education timeline may be shorter than that associated with the repurposing or expanding of an existing N11 code, but introducing mandatory 10-digit dialing where a post-dial delay or inter-digit timeout cannot be implemented in TDM switches in areas where the new non-N11 code corresponds to an existing central office code in a 7-digit dialing area may require the same amount of time or longer. Further, costs of education seem likely to be less for than the repurposing or expanding of an existing N11 code.

5.1.4: Implementation of Any of the Above Scenarios

A successful nationwide public education campaign to educate consumers on the new 3-digit abbreviated dialing code, the repurposing of an N11 code, or the expanded use of an N11 code, will require participation by the FCC, state commissions, and the relevant stakeholders, including the platform providers, the SAMHSA, the NSPL, the VA, etc. Based in part on some NANC members' experience with prior N11 code implementation and area code relief efforts, examples of such education efforts include:

- Development of the launch or rollout schedule to introduce the new 3-digit or N11 code and the implementation timeframe, somewhat similar to the implementation of the 811 code.
- Information posted on the FCC public education webpages.⁹⁶
- Information posted on service providers' websites to link to the FCC's webpages.
- Information posted on the state commissions' public education webpages.⁹⁷
- Consideration of the diverse demographics and language preferences or barriers to ensure communications are translated into different languages as needed.⁹⁸
- Consideration of segments of the population that may be more vulnerable.
- Public service announcements through television, radio, print advertising, social media, etc.
- Other advertising and signage, such as billboards, bus shelters, public transit centers, schools, etc.
- Consideration and communications for special dialing requirements, *e.g.*, dialing "9" to get an outside line in multi-line telephone systems or PBXs.⁹⁹

Key components of any successful nationwide public education campaign to educate consumers on a new 3-digit abbreviated code are funding and execution. Recommendations on sources of funding for such an extensive educational campaign are outside the scope of the NANC's charge. However, the NANC recognizes that relying on service providers alone to bear the cost of educating the general public is untenable and unrealistic.

5.2: Service Provider Tasks

The network implementation associated with a new non-N11 3-digit dialing code, the repurposing an existing N11 code, or the expansion of an existing N11 code, may vary based on whether the service provider is an

⁹⁶ For example, see <https://transition.fcc.gov/cgb/consumerfacts/211.pdf>.

⁹⁷ For example, see <http://www.psc.state.fl.us/ConsumerAssistance> and <http://www.psc.state.fl.us/Publications/ConsumerBrochures>.

⁹⁸ For example, see <https://www.fcc.gov/consumers/guides/stop-unwanted-robocalls-and-texts>.

⁹⁹ If 911 is expanded, then the implementation of Kari's Law by February 2020 will eliminate this need. See <https://www.congress.gov/115/plaws/publ127/PLAW-115publ127.pdf>.

ILEC, a CLEC, a cable provider, a wireless service provider, or an interconnected Voice over Internet Protocol (VoIP) provider. However, there are many areas of commonality amongst different types of service providers.

5.2.1: Wireless Service Provider Network Tasks

The following information is provided from a general wireless service provider perspective.

5.2.1.1: New Non-N11 3-Digit Dialing Code

Following are some of the tasks necessary to implement and test a new non-N11 3-digit dialing code from a general wireless service provider perspective:

- Assign the new non-N11 3-digit dialing code in the switch translations dialing plan for its “specific” purpose which will not allow any other uses for that 3-digit dialing code.
- Build the associated switch routing elements and ensure that the new non-N11 3-digit dialing code is routing correctly.
- Add logic to internal automated systems to implement any updates (*e.g.*, new cell sites that go on air, etc.), and test to ensure that updates are routing correctly.
- Maintain such switch translations and system processes on an ongoing basis.

5.2.1.2: Repurposed Use of an N11 Code

Following are some of the tasks necessary to implement and test the repurposing the use of an N11 code from a general wireless service provider perspective:

- Update the existing switch translations dial plan to the new “specific” purpose to ensure no other uses of the repurposed N11 code.
- Compile the list of switch translations that need to be updated, remove the old switch translations, add the new switch translations for the repurposed N11 code, and thoroughly test such new switch translations.
- Add logic to internal automated systems to implement any updates needed (*e.g.*, new cell sites that go on air, etc.), and test to ensure that updates are routing correctly.
- Maintain such switch translations and system processes on an ongoing basis.

5.2.1.3: Expanding Use of an N11 Code

With the exception of N11 codes where location-based routing is already in place and would not be changed, expanding the use of an existing N11 code may present more challenges for switch translations, since today some N11 codes may be used at the state, county, or city level and are associated with 10-digit numbers specific to the state, county, or city, or cluster of cell sites. Existing switch translations may need to be updated to direct calls to a nationwide 10-digit toll-free number associated with a single IVR platform that could manage the appropriate call distribution to either a national crisis line or a hotline that is geographically closer to the caller based upon the originating caller’s network information. However, it may be possible to add switch translations for areas unserved by the particular N11 without affecting existing switch translations for areas already served, thus avoiding the reconfiguration of the current platforms that may currently provide access to a crisis line. Regardless, thorough testing would be necessary in either scenario. Additional circuit and call-answer bureau capacity is expected to be necessary in order to accommodate increased call volumes resulting from the expanded use of any N11 code, including 911.

5.2.2: Wireline and Interconnected VoIP Service Provider Network Tasks

The following information is provided from a general wireline (*e.g.*, ILEC, CLEC, cable) and interconnected VoIP service provider perspective. It should be noted that network design may result in translation tasks being performed centrally or at various network edge elements, depending on deployment. Further, it should be

noted that not all service providers, including some interconnected VoIP providers, are notified of N11 deployments and/or routing changes by local authorities or call centers. For a national suicide prevention and mental health crisis hotline system to have universal coverage and the highest success rate, all types of service providers, including interconnected VoIP providers, will need to be made aware of local service deployments or expansions and how to properly route such calls.

5.2.2.1: New Non-N11 3-Digit Dialing Code

Following are some of the tasks necessary to implement and test a new non-N11 3-digit dialing code from a general wireline and interconnected VoIP provider perspective:

- Assign the new non-N11 3-digit dialing code in the switch translations dialing plan for its “specific” purpose which will not allow any other uses for that 3-digit dialing code.
- Build the associated switch routing elements and test to ensure that the new non-N11 3-digit dialing code is routing correctly.
- Add logic to internal automated systems to implement any updates (*e.g.*, additional community coverage requiring additional switching resources) and test to ensure that updates are routing correctly.
- Maintain such switch translations and system processes on an ongoing basis.

5.2.2.2: Repurposed Use of an N11 Code

Following are some of the tasks necessary to implement and test the repurposing the use of an N11 code from a general wireline and interconnected VoIP provider perspective:

- Update the existing switch translations dial plan to the new “specific” purpose to ensure no other uses of the repurposed N11 code.
- Compile the list of switch translations that need to be updated, remove the old switch translations, add the new switch translations for the repurposed N11 code, and test to ensure the N11 code is routing correctly.
- Add logic to internal automated systems to implement any updates needed (*e.g.*, additional community coverage requiring additional switching resources) and test to ensure that updates are routing correctly.
- Maintain such switch translations and system processes on an ongoing basis.

5.2.2.3: Expanding Use of an N11 Code

With the exception of N11 codes where location-based routing is already in place and would not be changed, expanding the use of an existing N11 code may present more challenges for switch translations, since today some N11 codes may be used at the state, county, or city level and may be associated with a 10-digit number specific to the state, county, or city. Existing switch translations may need to be updated to direct calls to a nationwide 10-digit toll-free number associated with a single IVR platform that could manage the appropriate call distribution to either a national crisis line or a hotline that is geographically closer to the caller based upon the originating caller’s network information. However, it may be possible to add switch translations for areas unserved by the particular N11 without affecting existing switch translations for areas already served, thus avoiding the reconfiguration of the current platforms that may currently provide access to a crisis line. Regardless, thorough testing would be necessary in either scenario. Additional circuit and call-answer bureau capacity is expected to be necessary in order to accommodate increased call volumes resulting from the expanded use of any N11 code, including 911.

5.3: Additional Implementation Timeframe Considerations

Expanding the use of 211 or 911 likely would result in different implementation timeframes. 211 is not ubiquitously deployed today like 911, so if 211 is expanded to include a national suicide prevention and mental health crisis hotline system, then 211 must be deployed ubiquitously to be effective and consistent with the intent of the Act. Further, 911 is typically answered almost immediately by a call taker, while 211 callers may need to navigate an IVR system first to reach a crisis counselor. Where such IVR systems exist, they may need to be significantly modified in order to accommodate crisis calling volumes. And staffing issues may exist between existing 211 and 911 operations, further impacting differences in implementation timelines.

If an N11 code were to be repurposed, then the translations changes would have to be made twice; first, an announcement would be tested and implemented to educate callers that the old purpose is no longer supported, and second, the announcement must be removed and translations changes implemented to route calls to the new national suicide prevention and mental health hotline system. As such, these efforts would need to be consecutive rather than concurrent, thus lengthening the implementation timeframe.

Section 6: Implementation Costs

This section addresses the possible implementation costs for service providers, states and localities, and the federal government. Although implementation costs for the various stakeholders should be considered as well, identifying those costs is largely outside the scope of the NANC.

6.1: Service Provider Costs

The service provider costs for implementation of expanding or repurposing an N11 code would vary depending on the solution selected. For example, if 611 were to be repurposed, then service providers that use 611 will need to notify their entire customer base of the change, and provide an alternate number for their customers. Conversely, if 811 were to be repurposed, then service providers likely have no need to notify their entire customer base of the change as service providers are not the providers associated with 811 service.

Perhaps the most cost effective solution for service providers would be the expansion of the 911 code because 911 is currently deployed nationwide, but there may be additional costs and other impacts to PSAPs, counties and other stakeholders that must be considered. Calls to 911 would follow the routing that is already established in service provider networks; however, expansion of any other N11 codes would be much more complex because some are deployed at a regional or more granular level, and/or are not deployed ubiquitously.

If a new non-N11 3-digit code were established, it would require coding and switch programming changes to add the new 3-digit code to all the switches in the network. However, some switches are unable to support any 3-digit dialing codes other than N11 codes, so the deployment may not be ubiquitous. For networks that can support a new non-N11 3-digit code, the new 3-digit dialing code could be network ready in a shorter timeline than the expanding or repurposing of an existing N11 code (as long as the 3-digit code selected is not already in use in the network).

The most costly solution would be if an existing N11 code were to be repurposed solely for a suicide prevention and mental health crisis hotline, as this would require multiple changes within the coding and switch programming of all of the switches in service providers' networks. First, changes would be required to implement an announcement or intercept message to notify those using the N11 code for its current use that it is being transitioned into a new service. Second, additional coding and switch programming changes would

be required, once the announcement or intercept period has ended, to update the routing with the new local or toll-free number for the suicide prevention and mental health crisis hotline. The timeframe to implement such a repurposing will depend on the N11 code selected, and whether translations require changes to be made at the switch level, the dialing plan level, the cell site level, or at the device level.

6.1.1 Network Translations Cost to Establish a New Non-N11 3-digit Code or Repurpose an N11 Code

To create a new non N11 3-digit code or repurpose an existing N11 code, every originating switch in the United States and its territories would require translations updates. The NANC estimated the potential incremental network operations cost to originating service providers by determining the total number of required dial plan changes, multiplied by the estimated time required for each change, and then multiplying that figure by the standard labor rates for the required skill level to perform the work.

Per the iconectiv LERG™ Routing Guide,¹⁰⁰ there are 137,703 distinct switch/rate center combinations. The estimated number of dial plans per switch/rate center is four. Multiplying the 137,703 switch/rate center combinations by four dial plans equals 550,812 total dial plan changes necessary to implement a new non-N11 3-digit code or to repurpose an existing N11 code.

The NANC has assumed that one hour and forty minutes of labor for each dial plan change is reasonable for the purposes of these calculations. This includes:

- 1) 20 minutes of dial plan design, planning, and technical project management,
- 2) 20 minutes of quality assurance testing,
- 3) 30 minutes for network translation changes, and
- 4) 30 minutes of network operations monitoring to ensure there are no adverse impacts from the change.

The labor rates used in the following calculations were derived from the Contract-Awarded Labor Category (CALC) tool.¹⁰¹ The tool is an official website of the U.S. government to help federal contracting officers and others find awarded prices to use in negotiations for labor contracts. The appropriate skill level to perform the required planning, translations, and network monitoring activities is a Telecommunications Engineering III, at an average hourly rate of \$105.00 per the CALC tool. The rate of \$105.00 per hour from the CALC tool is generally consistent with contract labor rates provided to private sector companies but can vary based on the location of the work and the years of experience for each laborer. The NANC used these contract labor rates due to the incremental nature of the work in implementing these unplanned dial plan changes, as this effort would be difficult for some companies’ personnel to absorb. However, some companies may elect to use existing employees to perform such dial plan changes.

To calculate the total cost to the service provider community, the NANC multiplied the total number of dial plan changes 550,812 by the estimated time per dial plan change of 1.6 hours, and then multiplied that by the contract rate of \$105.00 for a Telecommunications Engineering III for a total of \$92,536,416.

Cost Calculation Table

A	Total number of unique Rate Center + Serving Switch Combo	137,703
B	Estimated number of Dial Plans per unique Combo	4
C	Total number of Dial Plan changes = A*B	550,812

¹⁰⁰ See http://www.trainfo.com/products_services/tra/catalog_details.html#LERG.

¹⁰¹ See <https://calc.gsa.gov/>.

D	Estimated hours of labor to support each Dial Plan change	1.6
E	Average labor rate per hour from CALC tool	\$105.00
F	Cost per change = D*E	\$168.00
G	Total Cost to the Service Provider Industry = C*F	\$92,536,416

6.1.2 Network Translations Cost to Expand the 211 Code

To expand the use of the 211 code, any switch serving an area that does not have 211 would need to be updated with a new 211 to 10-digit telephone number. About 94% of Americans have access to 211 today, and therefore the NANC estimates that 6% of all originating switches would require translations updates to support the expanded use of 211 to a nationwide service. Presuming no changes are required to existing 211 translations and only new translations need to be built for dial plans that do not currently support 211, the service provider community cost for network translations changes are estimated to be \$5,552,185. This was calculated using the same methodology and CALC tool rates in Section 6.1.1 above.

6.2: States and Localities Costs

As noted in Section 5 above, educational efforts, regardless of the solution selected, will be required. If the solution is to repurpose an existing N11 code, a longer timeline for network implementation, general public notification and education will be required. The costs vary depending on the method of notification such as radio, television, public announcements, bill inserts, social media posts, newspapers, etc. Notification and general public education should be a coordinated effort between the stakeholders and the state commissions, local agencies, city and county agencies, and telecommunication providers. The level of effort for most state and local commissions and agencies to produce and implement notices and announcements should be minimal as most already have processes established, but additional funding for those activities likely will be necessary.

If the 911 code is expanded to include access to a national suicide prevention and mental health crisis hotline system, there are some factors that must first be addressed; for example, how to fund PSAPs that serve rural high cost areas. The increased funding must come from other sources to upgrade equipment, and to adequately train and staff the call centers. Many rural PSAPs are funded by counties that have limited revenue streams. To adequately address these issues, the stakeholders must be given the opportunity to further comment on factors that are related to implementation of the expansion of the 911 code and the additional challenges faced by many PSAPs, rural or otherwise. For example, additional funding sources may include grants, tax increases or 911 surcharge increases.

Finally, there also would be state and localities' costs associated with any expansion of other N11 codes or with the implementation of a new non-N11 3-digit dialing code. There still would be costs associated with notification, education, advertising, and all efforts deployed, as previously mentioned. For example, if the 211 code were to be expanded, then local 211 organizations likely would incur costs to ensure additional staff are available to handle potentially increased call volumes, and costs to ensure that the necessary trunk capacity is in place to handle those potentially increased call volumes.

6.3: Federal Government Costs

The FCC asked the NANC to estimate the costs that the federal government may incur to implement a 3-digit dialing code for a national suicide prevention and mental health crisis hotline, but at this time the NANC lacks information necessary to make such a determination. However, the NANC notes that many commenters (*e.g.*, various United Way organizations, mental health organizations and individuals that have survived or been

affected by suicide) have voiced the need for investment of resources and/or federal funding for the NSPL to be increasingly effective in its mission.¹⁰² The NANC recommends that the FCC solicit further comments from interested parties on these costs, as they may be in the best position to estimate these costs. This report may help inform potential commenters. The NANC recognizes that it makes little sense to designate a 3-digit dialing code for access to a national suicide prevention and mental health crisis hotline system unless funding is made available to implement the 3-digit dialing code, educate the general public about the hotline's availability, and to ensure that the hotline is appropriately staffed.

6.4: Other Stakeholder Costs

Other stakeholder costs may include:

- Costs to the entity receiving the hotline calls (staffing, overhead, etc.).
- Costs to modify an existing, or where needed, implement a new IVR system or similar call routing platform to route calls in the most efficient method.
- Costs to accommodate how calls may be handled in those rural areas where existing services are limited. For example, not all parts of the country have deployed 211 or certain other N11 codes, not all such operations may be operated on a 24/7 basis, and their ability to achieve necessary funding and to expand operations may be highly limited.
- General public education costs and the ongoing costs of public awareness.

The NANC recommends that the FCC solicit further comments from other stakeholders, as they may be in the best position to estimate these costs.

Section 7: Recommendations

In letters dated November 8, 2018 and February 22, 2019, the FCC directed the NANC to, by May 13, 2019, approve and submit to the FCC a written report that addresses the sets of requirements set forth therein. Specifically, the NANC was charged with developing a report and recommendation on the feasibility of establishing a 3-digit dialing code for a national suicide prevention and mental health crisis hotline system, whether such a 3-digit code should be established, and what 3-digit code should be established if such a code is established.

In the February 22, 2019 letter, the FCC asked the NANC to make the following recommendations:

- If an N11 code is expanded, which N11 code should be expanded and why?
- If an N11 code is repurposed from its current use, which N11 code should be repurposed and why?
- If a non-N11 3-digit code is established, which non-N11 3-digit code should be established and why?
- Of the above 3 options, which option would the NANC recommend?

Following are the NANC's responses for each of the above scenarios.

¹⁰² For example, see December 10, 2018 letter from United Way of Allen County (Indiana):

<https://ecfsapi.fcc.gov/file/12100614613010/UWAC%20Suicide%20Hotline%20Improvement%20FCC%20Comment%20121018.pdf>;

December 10, 2018 letter from Didi Hirsch Mental Health Services:

<https://ecfsapi.fcc.gov/file/1210025223036/Advocacy%20N11%20Letter%20OK.docx>; and December 9, 2018 letter from Ms.

Meghan Long: <https://ecfsapi.fcc.gov/file/1210139151623/Advocacy%20Letter%20for%20Hotline%20Improvement%20Act.docx>.

7.1: N11 Code Expansion

If the use of any N11 dialing code were to be expanded for the purposes of crisis and suicide calling, the NANC recommends 211 as the dialing code selection. Expansion of 211 is a logical recommendation since today many 211 call centers already answer suicide and mental health crisis calls, and about 25% of the National Suicide Prevention Line (NSPL) call centers are also 211 call centers.¹⁰³ The current 211 system has integrated IVRs with options to direct veterans and their families to the Veteran's Crisis Line (if chosen), and the majority of IVRs are already equipped with English and Spanish language options.¹⁰⁴ The need to enhance, expand, or potentially replace existing IVRs may be necessary as current 211 operations are expanded, or new 211 centers are introduced to accommodate additional suicide and mental health crisis calls.

To implement any 211 expansion, the following must be considered:

7.1.1: Implementation and Timeline Considerations

According to www.211.org, about 94% of the U.S. population has access to 211 services today,¹⁰⁵ but the NANC is not currently aware of any single report or resource that readily identifies current geographic areas of 211 coverage. In the absence of such a resource, entities such as AIRS and United Way should, in collaboration with network, platform, and 211 services providers, identify with specificity the geographic areas not currently covered. Once geographic areas currently lacking 211 coverage have been identified, a determination must be made regarding the extent to which current 211 resources and coverage must be expanded and how any such expansions should be engineered and funded. Collaboration and coordination among existing platform providers would be necessary at every stage in order to ensure proper coverage, call routing, network capacity, infrastructure capacity, and sufficient staff to handle increases to call volumes.

In light of such complex interdependencies and to avoid stranding existing vital resources, the NANC recommends the establishment of a single national 211 services administrator (211 Administrator). The functions of such a 211 Administrator should include coordination with SAMHSA, the Veterans Health Administration / VCL, AIRS and AIRS member entities, and other relevant entities, including those that do not have ties to SAMHSA, VCL or AIRS, in order to competently develop call volume forecasts and projections by type of call and geographic region. The 211 Administrator should also be responsible to determine proposed call handling and call routing approaches among the various entities that answer crisis and suicide-prevention related calls and provide specialized counseling and support, and should be expected to work with those entities to establish one agreed-upon plan. Network providers would rely on that agreed-upon plan, and on the call-volume projections provided by the 211 Administrator, in order to properly analyze the existence in their networks of sufficient end office and other connections, and supplement or add new connections wherever necessary to meet the provided projections. Similarly, administrators of the expanded 211 call centers would rely on such projections to ensure sufficient infrastructure and staffing.

It is presently unclear how long it may take to establish a 211 Administrator, and how long it may then take the 211 Administrator to collaborate sufficiently in order to produce the agreed-upon plan and credible forecasts and projections by region. Such timing will be based on the nature of the plan and its dependencies, such as regional platform readiness, including staffing, funding, and coordination with service providers. Additional tasks and timeline considerations are set forth in Section 7.1.2 below.

¹⁰³ According to March 15, 2019 email discussions with AIRS representatives.

¹⁰⁴ See SAMHSA Report to the FCC filed Feb. 7, 2019: <https://ecfsapi.fcc.gov/file/1022280990575/19021504-1.pdf>.

¹⁰⁵ See <http://www.211.org/pages/about>.

Another key function of the 211 Administrator could be to collaboratively develop a national consumer education plan. This collaboration could extend to include all of those entities identified above, as well as the Ad Council, federal and state governments, and possibly local governments in some areas. This consumer education plan responsibility should be recognized as critical to the success of the national deployment of a national 211 calling platform for suicide and mental health crisis calls, and the timing should be carefully coordinated in order to parallel the regional implementations.¹⁰⁶

Based on information supplied by SAMHSA, the use of an N11 number, such as the expansion of 211 has the potential to play a key role in improving national crisis intervention and suicide prevention efforts, but only if it is accompanied by efforts to develop a more coordinated crisis system with greater capacity and access to sophisticated data and technology systems, and an ongoing commitment to data driven quality improvement.¹⁰⁷

7.1.2: Additional Timeline Considerations

The FCC, or the 211 Administrator should Congress and the FCC proceed along that path, may benefit from the data the United Way likely already has that identifies the attributes associated with the remaining 6% of the population that is not currently served by 211.¹⁰⁸ Such data can be expected to help determine the desired timeline for that remaining 6% to be reached for expansion of 211.

Other timeline considerations must be made as to the time it will take for the appropriate organizations to staff and increase capacity in existing or additional call centers to support the increased call volumes to 211, and to augment IVRs accordingly. Additional timeline considerations are whether 24/7 access to a national suicide prevention and mental health crisis hotline system should be provided, and “rollover” processes established to ensure call abandonment is avoided if a particular 211 call center is unable to manage its call volume at a given time. Specific timeline information regarding these activities would best be gathered from those entities themselves, preferably by the proposed 211 Administrator, following any determination by Congress and the FCC to proceed with expanding the use of 211 for a national suicide prevention and mental health crisis hotline system.

To expand the use of 211, all network provider switches, including any switches that do not have 211 programmed today, may need programming updates to support the expanded use of 211, with updates to the underlying 10-digit telephone numbers or new numbers altogether. If the implementation means that no existing 211 translations or programming need to be updated and only new translations or programming added for areas not currently served by 211, then the timeline for implementation by originating service providers would be reduced.

Timeline considerations must also include consumer education. Such education should be done at the local, state, and federal levels, and may also include local businesses providing information to employees, and information being provided to public and private schools, including middle, high school, junior college, state college, and universities. Others include health care providers, fire departments, and police, as well as advertising to include radio, TV, billboards, social media, and public websites. Federal education should include all governmental websites, the VA and all branches of military service, and the state department. Finally, consumer education should start coincident with the deployment date of 211, and ongoing education

¹⁰⁶ See slide 23, SAMHSA report to the NANC on March 28, 2019: <http://nanc-chair.org/docs/FCCPresentation3.28.19V3.pptx>.

¹⁰⁷ See slide 18, SAMHSA report to the NANC on March 28, 2019: <http://nanc-chair.org/docs/FCCPresentation3.28.19V3.pptx>.

¹⁰⁸ See <http://www.211.org/pages/about>.

and promotion is likely essential to ensure that expanding 211 to include a national suicide prevention and mental health crisis hotline system has the desired impact on consumers.

7.1.3: Cost Considerations

Although it is not possible to produce credible variable-cost estimates, or even estimates associated with certain fixed costs, without the knowledge of regional call-volume projections and resulting network augmentations and other factors addressed above, it is possible to determine generally that overall costs associated with expanding use of 211 would be expected to fall well below levels that would be incurred to dismantle and repurpose any N11 dialing code whose current purpose has no common attributes with crisis and suicide calling. Nonetheless, following are some cost-estimate parameters and judgments from highly-experienced members of the NANC who possess relevant knowledge from their years of specialized experience.

Service provider costs such as network switch translations and programming, cell site analysis, and routing of calls are some relevant cost considerations for areas that currently are without 211 services today. The NANC estimates \$5,552,185 in service provider costs alone to deploy 211 to the remaining 6% of the population without access to 211 today. Until an implementation plan is developed by the 211 Administrator, in consultation with the platform providers and service providers, additional costs of the modification of any existing 211 services are unknown.

Some states and localities may incur costs as the result of request for funding for expansion of 211 where staffing and network capacity must be augmented in the current 211 systems so that all call centers are able to handle additional crisis calls if additional calls are projected.

Finally, a comprehensive public education and awareness campaign, as noted above, encouraging the use of the 211 code for access to a national suicide prevention and mental health crisis hotline system is practical and economical, since 211 is already marketed as the number to call for needs relating to health, human, community and social services.

7.2: N11 Code Repurposing

After review and analysis of the current purposes and usage of each of the N11 codes, the NANC does not recommend repurposing any N11 code. Each N11 code provides a valued service for some segment of public and that segment of the public utilizes such services. For example, the 711 code is likely well-known and used by TRS users but perhaps not the general population, and the 311 code is likely well-known by those living in large metropolitan areas but perhaps not by those living in more suburban or rural areas. Thus, there is no optimal N11 code to recommend for repurposing.

The NANC recommends the FCC and associated stakeholders periodically monitor and evaluate the uses and usage of the N11 codes to assess if any N11 codes should eventually be repurposed as consumers transition to newer technologies (*e.g.*, 711). If such a determination is made, the Commission should ensure that stakeholders are given sufficient time to vacate the current uses and allow significant time for those codes to remain “idle” for an extended period of time such that they may be more readily assignable for other purposes at some point in the future.

Of the N11 codes, 511, 711, and 811 appear to experience the least overall use.¹⁰⁹ If an N11 code must be repurposed, the NANC recommends that the 511 code because the service is not ubiquitously deployed, has

¹⁰⁹ See Section 4.10.

many alternatives to obtain such information, and may be the most expeditiously repurposed with the least impact to users. Thus, the 511 code has fewer societal, legislative, and regulatory impacts if it is repurposed. Ultimately, the NANC prefers its recommendation for expanding the 211 code as the most expedient and implementable solution, if any 3-digit code must be implemented.

7.2.1: Implementation Considerations

All service providers that currently have 511 deployed would need to vacate its use, and age the code to avoid its use where calls could be misdirected. All service providers would then need to implement the 511 code with the new use into their networks. Depending on the switch type, implementation of the 511 code ubiquitously among service providers would differ in cost and implementation time. Implementing 511 into VoIP and wireless networks could be relatively simple, as those service providers would need to program the 511 code for routing to a 10-digit number for the appropriate call center, based on the originating number or the cell site serving the originating number at the time the call is made. From a service provider perspective, this could become more efficient if the call is terminated to a national or centralized call center as opposed to a local or decentralized call center network. However, this could introduce more complexities for platform providers. TDM wireline networks would need to program the 511 code into switches for each local calling plan, and depending on the switch type and its capabilities, time for implementation could be significantly increased. Wireless networks will need to program the 511 code into each switch at minimum, and per cell site if calls are to be terminated to the closest local call center to where the call originated.

To support the new 511 code and the expected increased call volumes that a national suicide prevention and mental health crisis hotline system would receive, additional call centers and IVR systems may be needed. A designated “Project Manager” and appropriate parties will need to select the organization(s) which will be responsible for accepting calls to 511. Depending on the functions and services provided by the appointed organization(s) and/or the responsibilities delegated to the appointed organization(s), an IVR likely will still be needed to direct veterans to the Veterans Crisis Line, direct callers in immediate danger to dial 911, and to accommodate multiple language options. Additional call centers or staffing in existing call centers, as well as increased trunk capacity, likely will be needed to manage the increased call volumes expected.

A national education plan would need to be created to alert consumers of the new 511 abbreviated dialing code to reach the national suicide prevention and mental health crisis hotline system. The implementation of the 511 code should be shared with the public via various media outlets such as TV, radio, and print, and depending on the jurisdiction of the call centers, should be handled by the local and/or national branches of the appointed organization(s) as well as local and national governments.

7.2.2: Timeline Considerations

Given that 511 is an N11 code with a previous use, the implementation time may be longer than expansion of the 211 code or implementation of a new non-N11 3 digit code. The NANC recommends that the FCC solicit comments on such timing before submitting its final report to Congress. Such service provider updates and call center additions can be undertaken simultaneously.

Regardless of service provider technical feasibility and readiness for implementation, the hotline call centers must be properly set up to receive calls to 511, and ready to accept an increasing number of calls. Various aspects of the call centers will need to be reviewed, such as adequate staffing, additional trunk capacity, and IVR system implementation or augmentation to allow distressed callers to talk to counselors equipped to handle their type of emergency (*e.g.*, veterans, Spanish-speaking, etc.). In addition, it must be determined if all calls to the 511 code should transfer to a national or centralized call center or to a local call center, as this decision will further influence training and staffing needs, as well as trunk capacity needs.

To the extent that local and federal governments or other organizations are responsible for public education, they may begin marketing 511 via various media outlets such as TV, radio, print, and social media, once service providers have implemented the 511 code and the call centers are ready to receive such calls.

7.2.3: Cost Considerations

The cost to service providers varies, depending on service provider type, the quantity and what type of switches that must be updated, and the configuration of how calls to 511 must be routed. This would be in addition to removing the programming associated with the 511 code's previous use and the routing to a vacant code recording. Costs may be less if calls to 511 are terminated to a single centralized or national call center as opposed to local call centers which need individual translations.

The NANC estimates \$92,536,416 in service provider costs alone to repurpose 511. Until an implementation plan is developed by the Project Manager, in consultation with the platform providers and service providers, the additional costs of first vacating the current 511 code's use and routing those calls to announcement would vary across service providers and would require further consideration.

Funding for call centers will need to ensure adequate staffing and additional trunk capacity is in place to manage the additional call volume expected and make IVR adjustments as needed. Further, funding will likely be necessary for educating the general public about the new 511 code's availability.

With regard to costs that would be incurred by states, localities and the federal government, the NANC recommends that the FCC solicit comments on such cost responsibilities.

7.3: New Non-N11 3-Digit Code

If a non-N11 code is to be established, the NANC recommends the 988 code. The 988 code is an Easily Recognizable Code (area code) and is not currently assigned as an area code (consistent with NANPA's recommendations in Appendix B). Further, there are fewer corresponding 988 central office code assignments across the U.S. than some other easily recognizable codes the NANC considered,¹¹⁰ and selecting a code with fewer assignments minimizes the need to introduce a post dial delay or inter-digit timeout in TDM wireline switches where 7-digit dialing for local calls is the norm. If the 988 code is selected, then 988 as a central office code should no longer be assigned in area codes where 7-digit local dialing is still the norm (just as N11 codes are not assigned as central office codes in geographic area codes today).

However, the 988 code is not without technical and operational concerns. To accommodate 988 as a 3-digit code in areas where 7-digit dialing is still the norm and 988 is already assigned as a central office code, TDM wireline switches would need to implement (if possible) a post dial delay or inter-digit timeout so the switch can determine if the call originator intended to dial 3 digits to reach the national crisis hotline or dial 7 digits in the form of 988-XXX-X to reach a local number. Service providers with TDM wireline switches that cannot implement a post dial delay or inter-digit timeout would either 1) need to implement mandatory 10-digit dialing for local calls in those areas where the 988 central office code is already assigned, or 2) replace the switches, or 3) be exempted from being required to complete calls to the 988 code on a 3-digit basis for those switches. In that exemption case, consumers would have to be educated to continue to dial 800-273-TALK or other toll-free numbers to reach the crisis hotline if 988 wasn't supported by their service provider.

¹¹⁰ As of data reviewed in March 2019.

988 as a 3-digit code for the national crisis hotline can coexist with assigned 988 central office codes in TDM wireline switches where mandatory 10-digit dialing is implemented, and in wireless switches where the consumer presses the “green” button (or something similar) to indicate the end of the dialed digits (regardless of whether local calls can be made on a 7- or 10-digit basis). VoIP networks are likely able to support 988 as both a 3-digit code and as a central office code given many VoIP networks route based on 10-digit dialing. Indeed, 10-digit dialing could help simplify the implementation of 988 as a 3-digit code for a national crisis hotline, and could help advance nationwide number portability as well.

7.3.1: Implementation Considerations

All service providers would need to implement the 988 code as a 3-digit abbreviated dialing code to their networks (if technically feasible). Depending on the switch type, implementation of the 988 ubiquitously among service providers would differ in cost and implementation time. Implementing 988 into VoIP and wireless networks could be relatively simple, as those service providers would only need to program the 988 code for routing to a 10-digit number for the appropriate call center, based on the originating number or the cell site serving the originating number at the time the call is made. From a service provider perspective, this could become more efficient if the call is terminated to a national or centralized call center as opposed to a local or decentralized call center network. However, this could introduce more complexities for platform providers. TDM wireline networks would need to program the 988 code into switches for each local calling plan, and depending on the switch type and its capabilities, time for implementation could be significantly increased. Wireless networks will need to program the 988 code into each switch at minimum, and per cell site if calls are to be terminated to the closest local call center to where the call originated.

Service providers would need to review the areas they serve to determine where 7-digit dialing is the recognized dial plan. In areas where 7-digit dialing is available and the 988 central office code already is in use, either a post dial delay / inter-digit timeout or mandatory 10-digit dialing would need to be implemented in TDM wireline switches.¹¹¹ If mandatory 10-digit dialing is implemented, time for implementation could be significantly increased, as state commissions are responsible for setting the dial plans within the state. Post dial delay or an inter-digit timeout would not be required in VoIP networks because most require 10-digit dialing already, or in wireless networks because callers use the “send” or “green” button to signify the end of the dialed digits.

To support the new 988 3-digit code and the expected increased call volumes that a national suicide prevention and mental health crisis hotline system would receive, additional call centers and IVR systems may be needed. The appropriate parties will need to select the organization(s) which will be responsible for accepting calls to 988. Depending on the functions and services provided by the appointed organization(s) and/or the responsibilities delegated to the appointed organization(s), an IVR will likely still be needed to direct veterans to the Veterans Crisis Line, direct callers in immediate danger to dial 911, and to accommodate multiple language options. Additional call centers or staffing in existing call centers, as well as increased trunk capacity, likely will be needed to manage the increased call volumes expected.

A national education plan would need to be created to alert consumers of the new 988 abbreviated dialing code to reach the national suicide prevention and mental health crisis hotline system. The implementation of

¹¹¹ Using March 2019 central office code assignment information from iconectiv’s LERG™ Routing Guide (see http://www.trainfo.com/products_services/tra/catalog_details.html#LERG) and area code information from NANPA’s NPA Dialing Plans Report (see <https://www.nationalnanpa.com/enas/npaDialingPlansReport.do>), there are about eighty-eight 988 central office codes assigned in area codes where 7-digit dialing is permissible for local calls in the U.S. and its territories. Those 88 central office codes are assigned in area codes across 38 states and territories.

the 988 code should be shared with the public via various media outlets such as TV, radio, and print, and depending on the jurisdiction of the call centers, should be handled by the local and/or national branches of the appointed organization(s) as well as local and national governments. In addition, those consumers in areas that move from 7-digit to 10-digit dialing because post dial delay or inter-digit timeout could not be implemented would also need to be made aware of the new dialing procedures. Service providers with customers in those impacted areas could alert customers via bill inserts, bill messages, website notices, etc.

7.3.2: Timeline Considerations

Given that 988 would be a new abbreviated dialing code without a previous use (or very limited use), the implementation time may be quicker than repurposing an N11 code, at least for VoIP and wireless networks, but TDM networks may need as much or longer time to implement either 10-digit dialing or post dial delay/inter-digit timeout, where necessary. The NANC recommends that the FCC solicit comments on such timing before submitting its final report to Congress. Such service provider updates and call center additions can be undertaken simultaneously.

Regardless of service provider technical feasibility and readiness for implementation, the hotline call centers must be properly set up to receive calls to 988, and ready to accept an increasing number of calls. Various aspects of the call centers will need to be reviewed, such as adequate staffing, additional trunk capacity, and IVR system implementation or augmentation to allow distressed callers to talk to counselors equipped to handle their type of emergency (*e.g.*, veterans, Spanish-speaking, etc.). In addition, it must be determined if all calls to the 988 code should transfer to a national or centralized call center or to a local call center, as this decision will further influence training and staffing needs, as well as trunk capacity needs.

To the extent that local and federal governments or other organizations are responsible for public education, they may begin marketing 988 via various media outlets such as TV, radio, and print and social media, once service providers have implemented the 988 code and the call centers are ready to receive such calls. Service providers that require customers in 7-digit dialing areas to dial 10 digits because no post dial delay or inter-digit timeout can be implemented will need to educate those customers, which can be done via bill inserts, bill messages, etc.

7.3.3: Cost Considerations

The cost to service providers varies, depending on service provider type, the quantity and what type of switches that must be updated, whether a post dial delay/inter-digit timeout or mandatory 10-digit dialing must be implemented, and the configuration of how calls to 988 must be routed. Costs may be less if calls to 988 are terminated to a single centralized or national call center as opposed to local call centers that need individual programming. Generally, it's anticipated that TDM wireline providers that would need to implement post dial delay/inter-digit timeout or mandatory 10-digit dialing will have higher costs compared to wireless and VoIP providers. Overall, the costs to service providers to implement the 988 code are likely comparable to those that would be incurred if an N11 code is repurposed.

Funding for call centers will need to ensure adequate staffing and additional trunk capacity is in place to manage the additional call volume expected and make IVR adjustments as needed. Further, funding will likely be necessary for educating the general public about the new 988 code's availability.

With regard to costs that would be incurred by states, localities and the federal government, the NANC recommends that the FCC solicit comments on such cost responsibilities.

7.4: Other Considerations

With respect to the issue of mnemonic value of any N11 dialing code over any other for purposes of crisis and suicide calling, neither SAMHSA nor the VA, after their consideration, identified opinions or provided guidance. Nor has the NANC been able to otherwise identify any relevant mnemonic value in any N11 dialing code. Therefore, the NANC concludes in this report that there is no known N11 dialing code mnemonic value relevant to suicide prevention and mental health crisis calling.

7.5: Overall Recommendation

Initially this report supported increased public awareness and the use of the existing toll-free suicide prevention and mental health crisis hotlines, but the FCC then requested that the NANC make a recommendation on which type of a 3-digit dialing code can be implemented. Given the benefit of information provided by SAMHSA, the VA and AIRS, the NANC has found it technically feasible to recommend the “expansion” of the existing 211 code, if a 3-digit code is to be established. Expansion of the 211 code would be the most expedient and beneficial in providing easy access to suicide prevention and mental health crisis support service to help address what has become a national health crisis. If the 211 code is expanded, the NANC recommends that a “211 Administrator” be established to manage the effort.¹¹² As suggested by the SAMHSA,¹¹³ the NANC also recommends concurrent use of the existing toll free numbers (*e.g.*, 800-273-TALK, 800-SUICIDE) that have been institutionalized through traditional promotion and wide-scale use, at least until such time that their call volumes significantly diminish.

Finally, the NANC recommends that the FCC issue a request for comments on its report before providing it to Congress, and a Notice of Proposed Rulemaking before any final order establishing any 3-digit dialing code (N11 or otherwise).

Section 8: Cost/Benefit Analysis

The FCC asked the NANC to provide a proposed cost-benefit analysis comparing use of a 3-digit dialing code with the current use of a toll-free number to operate the NSPL. As discussed above, the costs of implementing any of the options would need to be weighed against the benefits to individuals in crisis. And to determine those benefits, it is necessary to determine whether any 3-digit abbreviated dialing code will prove more effective than improving or enhancing the existing toll-free number hotlines approach.

Whether a 3-digit abbreviated dialing code or a 10-digit toll-free number(s) is used, public awareness requires long term and continued investment. SAMHSA has been using 800-273-TALK with continued success, as evidenced in the increasing call volumes it has experienced since its inception.¹¹⁴ However, SAMHSA has pointed out that capacity to respond rapidly to the steadily increasing call volumes is imperative.¹¹⁵ Public awareness and the necessary capacity to manage increasing call volumes are certainly important considerations for costs for a cost/benefits analysis, in addition to other costs enumerated in this report.

¹¹² The recommended use of a 211 Administrator provides the benefit of planning and coordination among SAMHSA, the VA, the 211 organizations and other stakeholders for the expanded use of 211 to multiple suicide prevention and mental health crisis line platform providers. Such planning and coordination should include a comprehensive and continuing consumer education campaign that should alleviate the “dual purpose” concerns experienced in the wake of Hurricane Katrina when SAMHSA’s 800-273-TALK number was quickly utilized to support individuals in post disaster distress. See page 17 in the SAMHSA Report to the FCC filed Feb. 7, 2019: <https://ecfsapi.fcc.gov/file/1022280990575/19021504-1.pdf>.

¹¹³ See pages 14-15 in the SAMHSA Report to the FCC filed Feb. 7, 2019: <https://ecfsapi.fcc.gov/file/1022280990575/19021504-1.pdf>.

¹¹⁴ See slide 15 of the SAMHSA report to the NANC on March 28, 2019: <http://nanc-chair.org/docs/FCCPresentation3.28.19V3.pptx>.

¹¹⁵ See slide 13 of the SAMHSA report to the NANC on March 28, 2019: <http://nanc-chair.org/docs/FCCPresentation3.28.19V3.pptx>.

To quantify the costs associated with implementing the 3-digit code remains difficult given the uniqueness of each service provider's network, and the diverse and evolving technologies that drive them. Call volumes and disruption of existing services is another significant cost that must be considered. However, as discussed in detail in this report, the expansion of the 211 dialing code could be far less costly, faster to implement, and less disruptive to users, than would result from the repurposing of any N11 code. Hence, the benefits of expanding use far outweigh any attempt to repurpose any N11 dialing code.

Considering that the 211 code has been partially implemented throughout the U.S. for suicide and crisis call centers already, there is potentially a great benefit to expand this practice. By adopting the expansion of 211 as discussed above, the benefits of expedient implementation is certainly a measurable benefit for a national health crisis.

Appendix A: NAOWG March 7, 2019 Data Request to Service Provider Associations

March 7, 2019

Ms. Mary Lovejoy, ACA (mlovejoy@americancable.org)	Mr. Michael Jacobs, ITTA (mjacobs@itta.us)
Ms. Courtney Neville, CCA (cneville@ccamobile.org)	Mr. Steve Morris, NCTA (smorris@ncta.com)
Dr. Bob Roche, CTIA (rroche@ctia.org)	Mr. Brian Ford, NTCA (bford@ntca.org)
Ms. Angie Kronenberg, INCOMPAS (akronenberg@incompas.org)	Mr. Kevin Rupy, US Telecom (krupy@ustelecom.org)
Mr. Chris Shipley, INCOMPAS (cshipley@incompas.org)	Mr. Glenn Richards, VON Coalition (glenn.richards@pillsburylaw.com)

Dear Service Provider Associations,

The FCC has tasked the North American Numbering Council (NANC), through the NANC's Numbering Administration Oversight Working Group (NAOWG), with developing a report and recommendation on the feasibility of establishing a three-digit dialing code for a national suicide prevention and mental health crisis hotline system, per the FCC's tasks under the National Suicide Hotline Improvement Act.

In an initial draft of the report, the NAOWG had provided some anecdotal, aggregated call volume data for the 211, 311, 411, 511 and 611 three-digit codes from a small subset of service providers that a few service provider associations and individuals on the NAOWG were able to gather and aggregate. In the FCC's [second referral letter](#) on this topic, the FCC has asked the NANC to consider which of the existing N11 dialing codes should be repurposed and "obtain and analyze call volume/utilization data for the recommended code, compared to other codes, from as large a service provider sample as possible."

In connection with this latest request, the NAOWG is asking service provider associations to ask its members to provide such data to the association (or their third party accounting firms) under terms of confidentiality, and asking the associations/accounting firms to aggregate the data. This should alleviate any competitive concerns or concerns about identifiable data. The NAOWG is asking the associations/accounting firms to provide only aggregated and anonymized data to me. As the NAOWG's co-chair, I will then aggregate the data from each of the associations further into a single code-specific "telecom industrywide" total. These totals will be included in the NANC report. Following are the parameters of the request:

- Total call volume data for the period December 1, 2018 through February 28, 2019 for each of the eight N11 codes separately (i.e., 211, 311, 411, 511, 611, 711, 811, 911). No need for service providers to break the data out by month, just provide the total for the period for each N11 code.
- If a service provider doesn't support a particular N11 code, the service provider should still include call attempt counts to each N11 code.
- If a service provider is unable to obtain call volume data for the specified period, the service provider should calculate the equivalent. For example, if the service provider is only about to obtain call volume data for February 1 through 28, 2019, then the carrier should triple its figures for that 1-month period to equate to the 3-month period.
- Call data for each N11 code should include calls to N11, #N11 and *N11, but only if all are translated for the same purpose.
- Associations should aggregate the data they receive from members, but provide a list of the service providers that contributed the data for each N11 code, unless only one service provider contributed data for that particular N11 code. This will allow the NAOWG to provide a count of and list of the service providers that the "industrywide" figures represent in the report.
- Service providers that belong to multiple associations (e.g. CTIA and CCA) should provide data to only one association to avoid duplication or skewing of the data.

Please provide the aggregated data to me no later than March 29, 2019; I believe that will give service providers enough time to gather and provide the data, and for associations to aggregate the data before providing it to me. It's critical that the NAOWG receive the data as quickly as possible as it will help inform the NAOWG in making its recommendations.

Please don't hesitate to give me a call if you have any questions.

Sincerely,

Carolee Hall

Carolee.hall@puc.idaho.gov

208-334-0364

Appendix B: March 13, 2019 NANPA Response per Second Referral Letter

March 13, 2019

Dana and Carolee,

In response to the FCC's February 22, 2019 correspondence to the NANC regarding the National Suicide Hotline Improvement Act of 2018 and direction to consult with NANPA, we can provide the following comments to the specific question posed:

If the NANC recommends designating a new code that does not use a number sign or star (e.g., 999), we direct the NANC to consult with the North American Numbering Plan Administrator to determine (1) if there is a specific code or codes best suited for this purpose, and (2) the impact of using that code or codes on North American Numbering Plan exhaust.

The NANC draft recommendation from the February 14, 2019 NANC meeting provided assumptions on the use of N11s and the difficulty of introducing a three-digit number starting with 0 or 1, due the exclusion of the 000 to 199 range from the North American Numbering Plan. We will limit our response to those resources under the North American Numbering Plan Administrator's management.

Out of the possibilities of NPA assignments outlined in the NPA Allocation Plan and Assignment Guidelines, we would recommend the assignment of an Easily Recognizable NPA Code (ERC). ERCs, due to the unique digit pattern (N22, N33...N88), have been used as non-geographic codes, and have been used to identify services rather than geographic areas. As of February 2019, there are 37 NPAs available for assignment/use as an ERC. The specific ERCs available for assignment can be downloaded from the NANPA website at https://nationalnanpa.com/reports/reports_npa.html, under the NPA database CSV file.

Using a 3 digit code out of the General Purpose Category (GPC) is also a possibility, although NANPA must identify NPA codes from the General Purpose Category when an existing geographic NPA is forecasted to exhaust and no NPA has been reserved for its relief. There are currently 41 General Purpose Codes available for assignment as seen in the attached NPA inventory dated 02.28.19. That number could change as a result of the April 2019 forecast projections, and I can provide an update after those forecasts are published. If a General Purpose Code is used for a purpose other than relief of an exhausting geographic NPA, although there is no evidence to show a large impact on NANP exhaust, it would impact the availability of the remaining geographic NPAs. It could also set a precedent of using the General Purpose Category for services rather than for relief of exhausting geographic areas.

Let me know if you have any questions, and if you'd like me to provide the potentially updated amount of General Purpose Category codes left after NANPA has published the April 2019 forecast projections.

Beth

Beth Sprague, NANPA Director
571-363-3821
bsprague@somos.com

Appendix C: March 19, 2019 Veterans Crisis Line (VCL) Response to NAOWG N11 Inquiry

Please note: Projections are based upon available information and could be inaccurate. Further analysis of sophisticated and collaborative forecasting data is necessary.

1. **Projections:** Under VCL Mission and Description on page 4 of the VA response, more than 3.8 million calls to the VCL are cited along with nearly 112,000 emergency services dispatches. Also cited are nearly 108,000 texts and more than 439,000 chats.

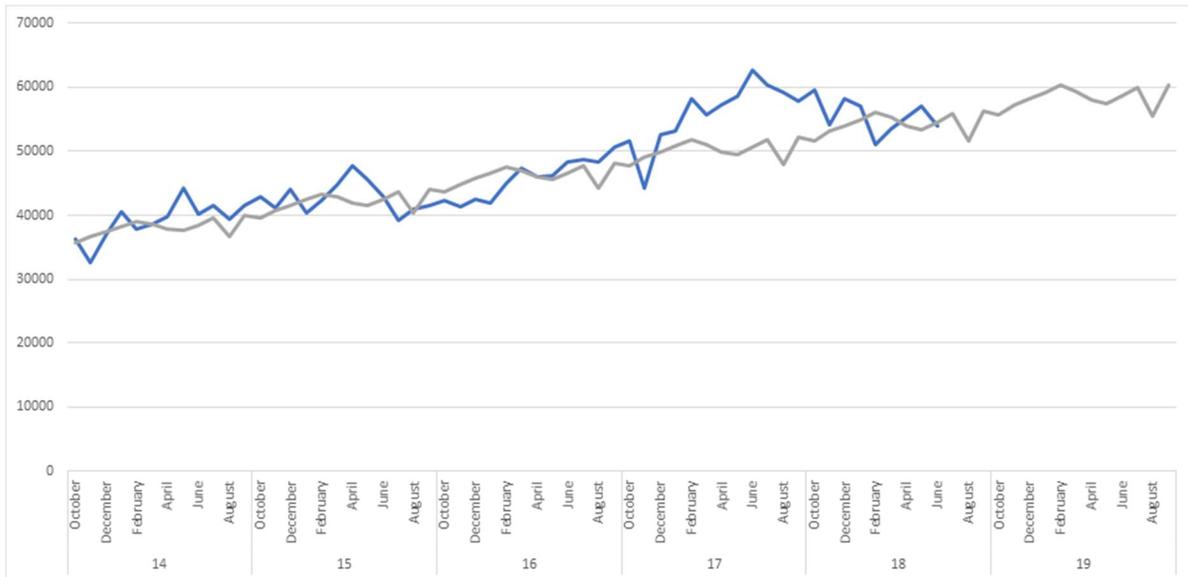
a. What is the historical breakdown of each of calls, dispatches, texts, and chats, by year?

The VCL has call volume data dating back to FY 2007. The chat program started in 2009, while the texting program started in 2012. Please see the graph below for the FY total volume of calls, chats, texts, emergency dispatches and referrals. Note- these are actual answered volume, not offered or inbound volume.

Time Period	Total Calls Answered by VCL	Answered Texts	Answered Chats	Initiate Dispatch of Eme	Referrals
FY 18 Total	632,682	26,895	73,919	29,271	116,033
FY 17 Total	635,581	20,365	58,109	23,570	116,053
FY 16 Total	510,173	15,816	53,660	12,119	86,760
FY 15 Total	490,378	16,388	58,879	11,044	81,205
FY 14 Total	450,940	13,272	64,923	9,709	71,667
FY 13 Total	323,331	10,943	57,711	7,958	58,260
FY 12 Total	239,515	3,823	44,278	6,617	40,247
FY 11 Total	164,101	NA	19,003	6,845	29,336
FY 10 Total	134,528	NA	8,265	5,792	19,970
FY 09 Total	118,984	NA	863	3,709	13,960
FY 08 Total	67,350	NA	NA	1,749	6,264
FY 07 Total	9,379	NA	NA	139	739
Total since Ir	3,776,942	107,502	439,610	118,522	640,494

b. Are there any scientifically-based projections on the growth of overall calls, dispatches, texts, and chats? (If so, please provide for all years available.)

The VCL was able to run a baseline forecast of demand growth using actual volume. Baseline growth was completed by using a time-series Simple Linear Regression (SLR) model. Our SLR model is forecasting roughly 700,000 calls in FY19. Due to anticipated changes in VCL call routing and national advertisement campaigns, this estimate could be off by as much as 50,000 calls on either end for a 650k-750k range for FY19. The blue line below is our historical call volume through 9/30/2018. The grey line includes the forecasted SLR call volume, including FY19 as a projection.



c. What percentage do calls, texts, and chats to VCL comprise of the total number of calls, texts, and chats nationally to analogous crisis and suicide lines? In other words, what is the total of all calls, texts, and chats to crisis and suicide resources such as VCL (including VCL counts as a component)?

The VCL represents 23.67% of the National Suicide Prevention Lifeline call volume to 1-800-273-8255 YTD for FY 2019. The VCL call volume also represents around 2.5% of the total 2-1-1 call volume (based on 60-day data provided by NANC report). We estimate around 2.4 million calls a year to 211 are mental health related by researching publicly available 211 center reports. If accurate, VCL would represent around 26% of 2-1-1 mental health volume. The VCL, however, is only directly related to the Lifeline volume through the 1800-273-8255 number. Other estimations are based upon reported volume for those organizations and comparing size. Another consideration is the fact that less than 7% of the US population are Veterans; a Population slowly decreasing in size due to natural demographics changes and the US military downsizing trend. The Lifeline does have chat volume that can be compared against VCL chat data. VCL’s chat data is included in response 1.a. While the VCL does not have text data for other organizations to compare, the VCL recognizes that the Crisis Text Line is a national text-based crisis intervention and support text service that has important outcomes for non-federally supported nationwide care. There are also several state and community behavioral health text services across the United States.

Per the Crisis Text line (more in resources section):

- **Usage Over Time.** These numbers reflect the total number of unique contacts (CTL call them conversations) that they have handled in the US each year since launch.
 - 2013:** 13,267
 - 2014:** 88,564
 - 2015:** 172,798
 - 2016:** 424,578
 - 2017:** 917,997
 - 2018:** 1,143,054

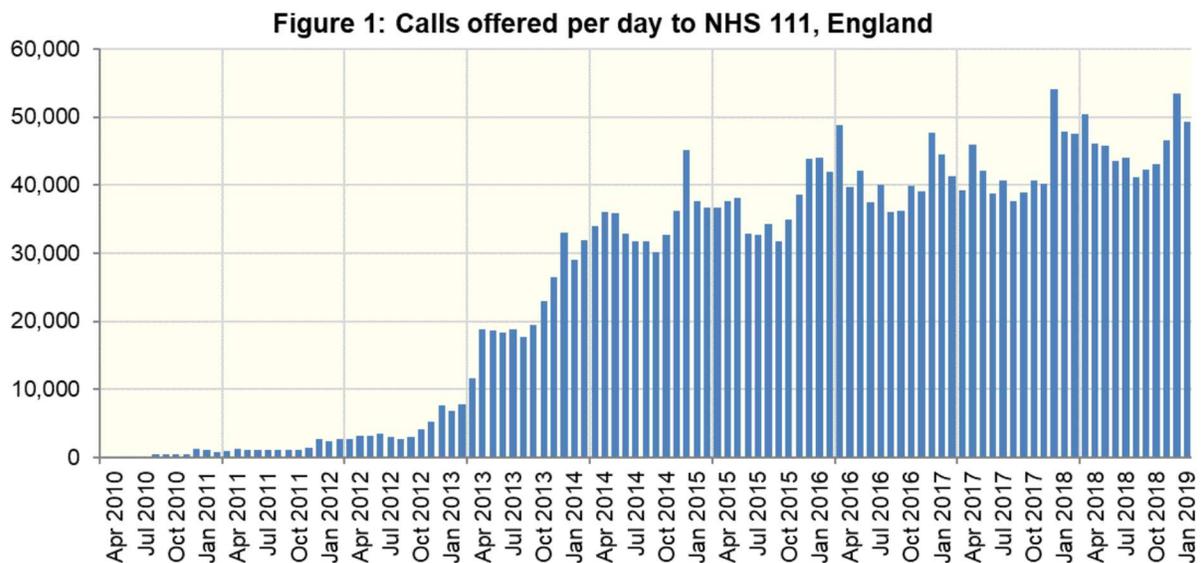
d. What other empirical data can you provide that may assist us in determining the overall “market” (for lack of a better term) in the context of call volumes for the services of such crisis and suicide lines nationally on a historical and going-forward (projection) basis?

While the VCL believes there is no direct comparison for a true market analysis on the impact a N11 code would have on behavioral health and crisis intervention calls for public or veteran/military populations, we were able to complete a few theoretical models to provide estimates of potential call volume and demand

for a 3-digit service. These projections come with many caveats and uncertainties but do provide a baseline for discussion around potential impact for 3-digit expansion.

The first model builds off the recent expansion of the United Kingdom’s 111 health line service. The England NHS model was launched in March 1998 to provide 24-hour NHS telephone general helpline for the public. This was meant to offset calls to the 999 service, similar to the United States 911 service (police, fire, EMS response). It was made available throughout England. In 2008, the UK made the decision to introduce a memorable, free-to-call, three-digit telephone number (subsequently 111) to improve access to urgent care services. The original 0845 number was switched off in February 2014 and NHS Direct closed on 31st March 2014. NHS 111 number was rolled out in April 2013. In 2017 NHS England and NHS Improvement published the Next Steps on the NHS Five Year Forward View which highlighted the importance of delivering a functionally integrated urgent care service to help address the fragmented nature of out-of-hospital services. A next major phase of 111 expansion is the integration of nationwide mental health response through the NHS pathways program. Here is the call volume to date for the NHS 111 integrated health line service by year, month and day. The second graph demonstrates rapid growth to the service once public:

Year	Total Calls Offered	Average per month
2018	16,646,556	1,387,213
2017	15,012,166	1,251,014
2016	14,724,997	1,227,083
2015	12,949,281	1,079,107
2014	12,068,567	1,005,714



There were 1,527,401 calls offered to the NHS 111 service in England in January 2019, an average of 49.3 thousand per day. This was an increase of 3.1% on 47.8 thousand per day in January 2018.

Using the England model, call outcomes and annual projection for FY19, the VCL projects a mental health demand for an N11 number to be around 2,381,600 calls a year. See graph below. This considers the current veteran mental health percentage of 21% in the VA:

	Vet Comparison
England population	56,000,000
Calls in January	1,527,401
Calls Annual Projection	18,328,812
Mental Health%	21.0%
MH calls	3,849,051
	Veteran Population
US population 330m:	20,790,000
projected call volume with 60% core	2,381,600

The current core response rate for the VCL is roughly 60% (see graph under 1.F). England has a population of ~56 million. The US has a Veteran population of ~20 million. Basing projections off actual call volume from previous months of NHS 111 data, VCL forecasts somewhere around 18 million calls being offered to NHS 111 in FY19. VCL estimated the call volume that would have been mental health related by looking at the differences between veteran population and civilian population behavior in calling similar lines such as 2-1-1. VCL compared this information with data obtained from the VHA corporate data warehouse to estimate veteran population with MH encounters for more accuracy.

Combining this data together, if the VHA were to use this model as a guideline, VCL could anticipate a national 3-digit number resulting in an estimated 1.4 – 2.4 million calls a year, including current call volume. Current volume is included because we are looking at the entire population as a replacement to current systems. The Lifeline projection could have a call volume between 9.7 and 16.2 million calls a year. Total market is between 11 and 18.5 million calls annually.

This would be basing our numbers off the assumption that 100% of the US population is reached and has access, it assumes no increase or decrease in utilization percentage, and therefore has a potential to overestimate call volume nationally. This does not include potential accidental, redirected or misdirected call volume though, which is a potential significant impact for 3-digit numbers (such as those from other N11 responses: 911, 211, 311). VCL is aware that this model is on the higher end of the projection. The next projection will be on the low end to provide a full range.

2-1-1 model. Description is below the table:

2-1-1 annual call volume	25,876,032
2-1-1 MH%	9.60%
MH core	2,484,099.07
MH w/noncore	4,140,165.12
23.6% to VCL	977,078.97
VCL now	650,000
VCL projected	1,627,078.97

Based off the numbers shared in the original NANC report, 2-1-1 currently receives nearly 26 million calls a year. Of those calls, 9.6% or around 2.5 million calls are identified as MH calls. The VCL used data from

<https://211counts.org/home/index> and physically reviewed each state. The estimate utilizes approx. 20% of the 211 call volume.

VCL, along with most other call centers, see a significant portion of calls identified as non-core calls. Using historical estimations, to receive the 2.5 million core calls, the inbound call volume would be nearly 4.2 million. The veteran population appears to have higher rates of suicide and mental health reason codes in the US. Using the current ratio of NSPL to VCL call volume, VCL assumes that 23.6% of those 4.2 million calls would be directed to the VCL. Because this service is in place and would be in addition to the current VCL structure, we add current volume to the projected increase from 2-1-1. Under this model, VCL call volume would be around 1.6 million calls a year, an increase of almost 1 million. NSPL would see an increase in their call volume of around 3.2 million to a total call volume of almost 4.6 million a year. Total market between both centers would be around 6.2 million calls a year.

This assumes the only increase is from 2-1-1 mental health volume and does not account for other services in place; therefore, this model has a potential for underestimating demand. The benefit of this model is that it provides a foundation to build on. A floor for what volume could be expected.

Conclusion: VCL could have between 1.6 and 2.4 million while NSPL could have between 4.6 16 million calls of demand. This does not mean the VCL will only see 1.6-2.4 million calls though, due to the complexities of funding and staffing smaller centers within the lifeline network. If funding is not in place to grow both organizations accordingly, one organization or the other could see an influx of spillover demand that the other does not adequately support.

- e. **If you have any other references or resources that you believe to potentially be of value to us as we gauge projected call volumes, please share.**

There are several resources that may be able to point to potential impact of N11 MH expansion. First, the American Association - www.suicidology.org/resources/fact-sheet. This is a collection of fact sheets that are available every year of national suicide statistics as soon as they become available from the National Center for Health Statistics. The most current statistics are from the year 2017.

Also, the Substance Abuse and Mental Health Services Administration releases annually its projections of those who are suicidal in the United States (attempted suicide, seriously considered, etc.) through the National Survey of Drug Use and Health (NSDUH) <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health>. This information can be used to identify a base population one would hope to reach with a mental health crisis line for prevention, intervention and postvention.

The VCL and the Lifeline both have resources about services online at www.suicidepreventionlifeline.org and the www.veteranscrisisline.net. This is included to remind the FCC that an expansion not only impact callers, but also other non-telephony based systems. The VCL provides chat, text and social media engagement that would be impacted as well as the phone expansion.

Finally, per the Crisis Text Line, there were several findings relevant for veteran engagement in National response texting that should be considered:

Conversation Content. About **1% of these conversations** explicitly mention a veterans/military related term (such as veteran(s), military, army, navy, air force, marines, cadet, colonel, fighter jet). The top three issues that are discussed in these military conversations are:

- Relationships (45% of convos)
- Depression/Sadness (44% of convos)
- Stress/Anxiety (38% of convos)

These military texters stand out from other conversations for being 2X more likely to talk about **finances, sexual assault, and grief. Texter Demographics.** They surveyed the texters after their

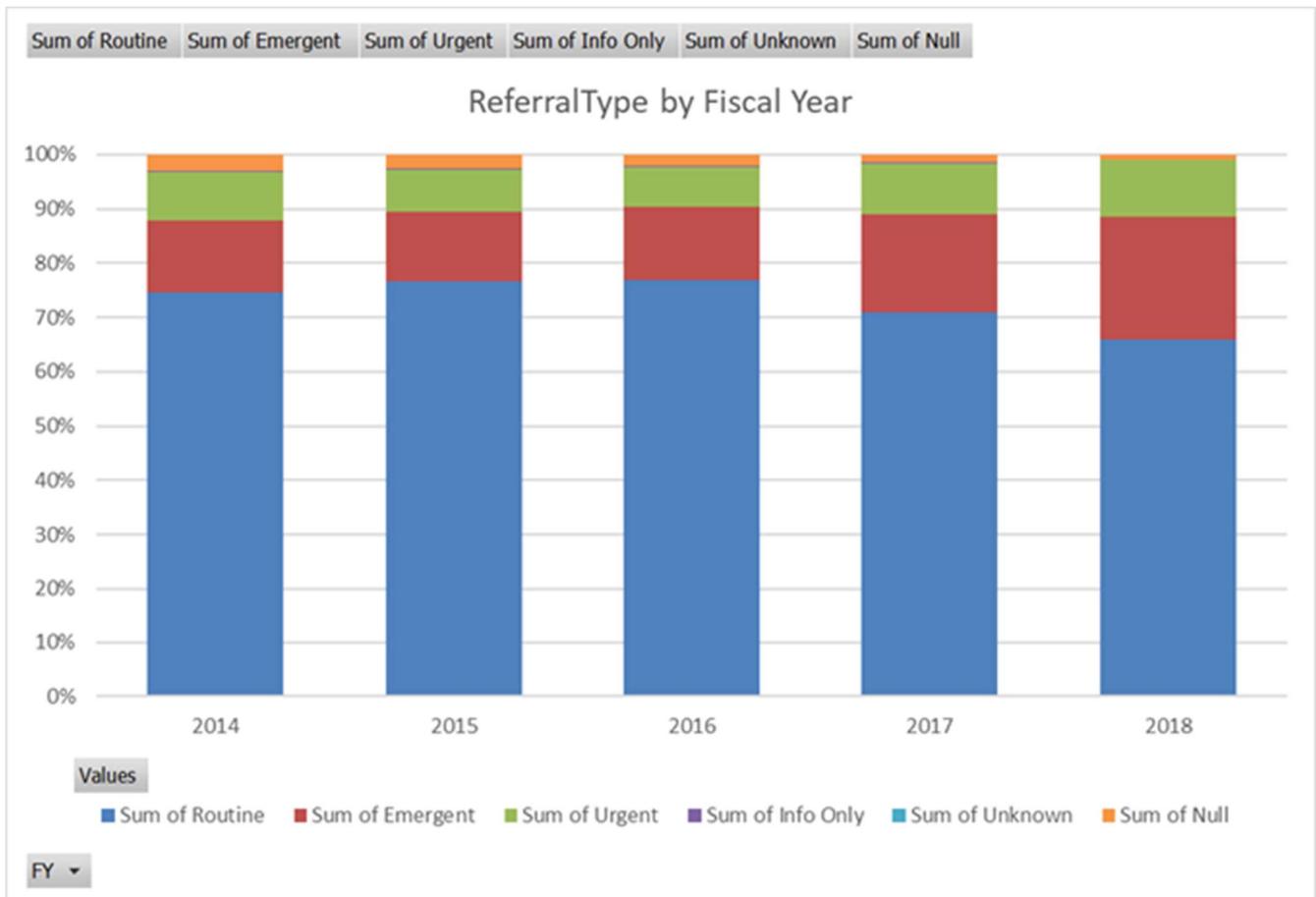
conversations and ask about their demographics (~20% fill out the survey). From this survey they know that:

- 1.2% of respondents report being a Veteran.
- 0.5% of respondents report actively serving.

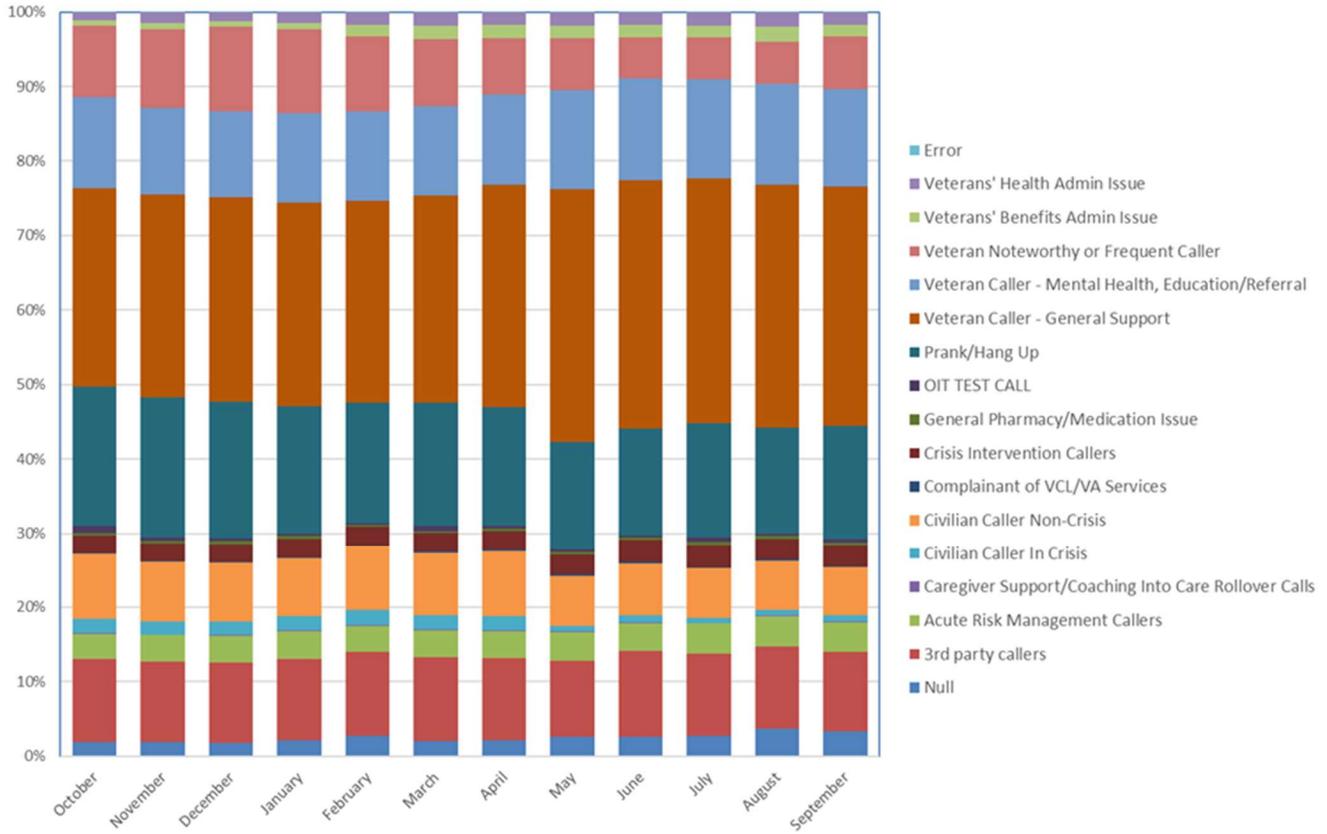
f. **If you have specific breakdowns of dispatch types and characteristics, please share. For example, how many dispatches involve threats of violence or death to others rather than threats of violence or death to solely the crisis-caller’s self? (I am asking in an effort to understand the frequency of need for dispatches of various types since such information may be relevant to the NANC recommendations.)**

Below (first two graphs) are examples of call referral outcomes of the VCL. Note: The VCL referrals/consults are referrals to suicide prevention coordinators and thus do not have the same definition as other agencies. If the question is specifically regarding emergency dispatches or “Rescues”, that data is contained above in response to 1a. Also note that data for call typing contains chat transfers to phones, backup center referrals, and other correspondence which is not a direct reflection of VCL call volume.

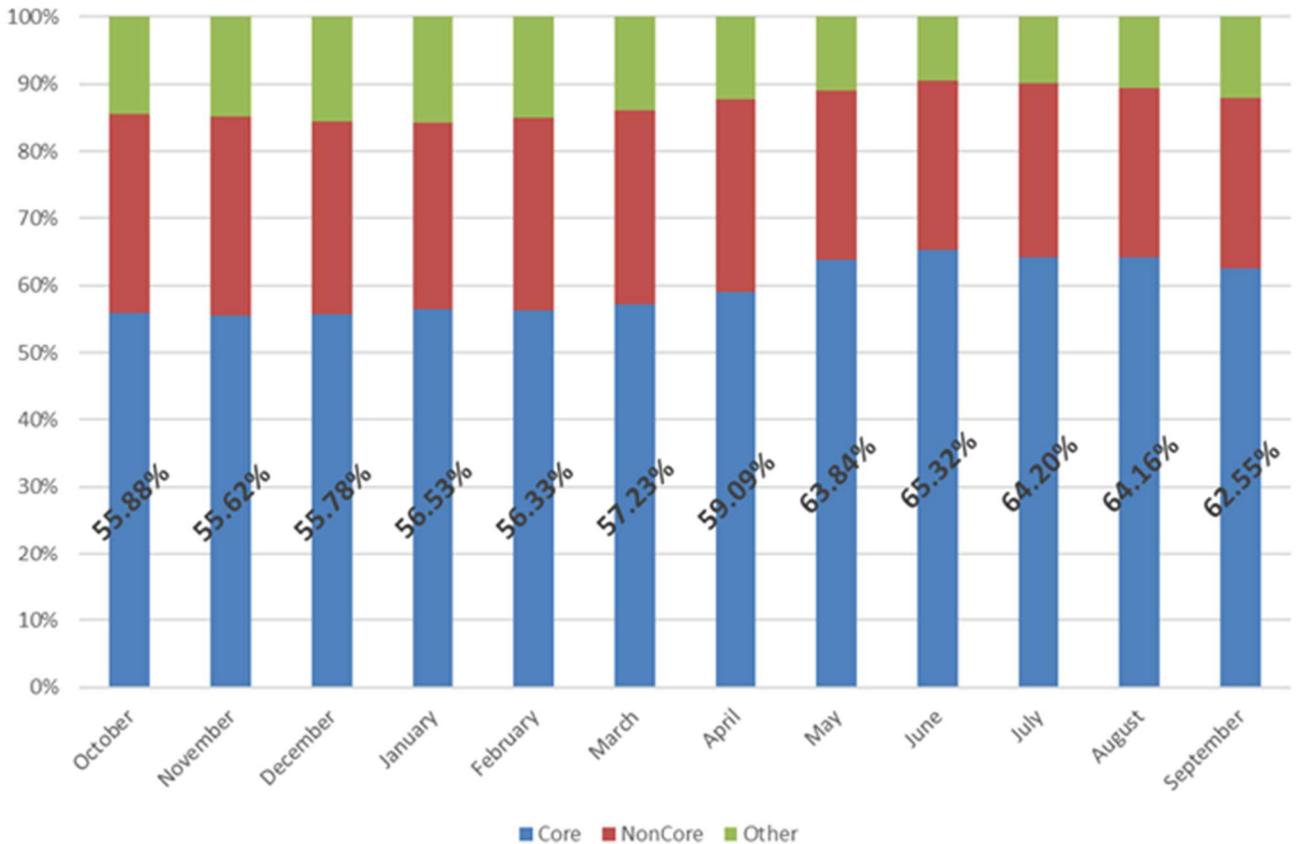
Row Labels	Sum of Routine	Sum of Emergent	Sum of Urgent	Sum of Info Only	Sum of Unknown	Sum of Null
2014	53475	9477	6446	161	0	2108
2015	62243	10489	6204	233	0	2036
2016	66736	11686	6295	206	0	1837
2017	82403	20795	11070	152	0	1633
2018	76434	26316	12230	83	0	970
Grand Total	341291	78763	42245	835	0	8584



Call Type FY18



Core Call % FY18



2. **Interactive Voice Response:** Also, under VCL Mission and Description on page 4 of the VA response, there is a reference to the use of an IVR system at the reference of “option 1.” There are further discussions of the use of IVRs on page 5 under the heading “Relationship with SAMHSA / V!brant.”

- a. Please identify and briefly describe the IVR decision tree(s). In other words, what are the options that a caller may encounter?

The VCL does not currently use an IVR. The IVR in use is managed by V!brant through the cooperate agreement grant issued by SAMHSA and encountered when a caller dials 800-273-8255. The choice is to Press 1 to speak to the Veterans Crisis Line. Once the caller reaches the VCL, there are no other IVR choices.

- b. Briefly, what key successes and key failures have been encountered by the use of IVRs for crisis and suicide callers to the VCL?

Success perhaps can be measured by the number of calls received by the VCL. While this method was never tested against an alternative, there is no doubt that Press 1 for the VCL presents an effective means of contacting our unified center and our crisis responders. Again, failures have never been determined by any scientific measure. One prevailing thought is that the number of “non-core” calls received (other than Veterans/Active Military in crisis) is due in part to (1) the ease of Press 1 knowing a person will answer &/or (2) muscle reflex of callers accustomed to “Press 1” for English IVR choices encountered on so many present-day systems.

- c. Do you believe that the key successes referenced in 2.b., above, can be replicated through the use of similar IVR decision trees under other platforms such as that which would exist if an N11 code were to be utilized for suicide and crisis callers, and do you believe that the key failures can be avoided under such an N11 use? Why?

We believe the successes can be replicated, if not magnified, by providing an easier to remember N11 number tied to the ease of Press 1. By the same token, we suspect that the very same factors contributing to success may also result in a greater failure: N11/Press 1 being used for other than VCL core calls. Depending on the resulting volume, these failures could be more impactful if the volume of non-core calls was such that access to our services, for those truly in need, was delayed.

Regardless of the reason for an increase in call volume (i.e. success or failure of N11), the VCL would need an accurate and fact-based estimate of the volume to expect to staff to appropriate levels and maintain our current level of service.

3. **911 Shared-Use Scenario:** 911 PSAPs/call centers have access to location information, Kari’s Law access from multiline premises equipment, immediate emergency-dispatch capabilities, and call-transfer capabilities. Please describe in a few paragraphs the relative benefits of having a dedicated N11 code for crisis calling compared to benefits of having a shared infrastructure with 911 that has such capabilities. (Note that I am asking this to gain an objective understanding, and I am not suggesting that one approach is better than the other. I recognize the very-substantial investment by all entities involved in the deployment of such 911-specific capabilities, and the unlikelihood that all such capabilities could reasonably be deployed for another N11 code or for any other dialing arrangement.)

There are several potential benefits to a shared infrastructure with 911 that can be identified. First, there is a benefit to having access to real-time geolocation-based services when engaging in emergency intervention with suicidal callers. Also, 911 is currently marketed for individuals in an emergency nationwide and is embedded in the fabric of American society.

That said, there are several advantages to the creation of a new N11 system for behavioral health crisis response. First, 911 would need to build an infrastructure behind its response in order to adequately provide the same level of service that the Lifeline and VCL provide. This includes staffing, training and significant expansion of services, not just for those in crisis. Noting that the American Association of Suicidology recently identified that there are over 700 crisis centers in the United States, there is currently a significant investment by states and communities to respond to those in BH crisis that can continue to be built from and integrated in a unified response. Finally, 911 has never been marketed for a mental health crisis response system. Many individuals who contact the VCL and the Lifeline do not need emergency intervention of police engagement and cognitively link 911 with police. It can be assumed that many people who would have otherwise called a N11 for mental health crisis would not call 911 for help. This would especially be true for our nations veterans and military personnel needing mental health support.

As for the VCL, the service would need to remain a separate service. The VCL is legislatively mandated and supported by the United States Government to respond to veterans, service members and their families in behavioral health crisis. The service itself could potentially work as a choice similar to the IVR currently in place with SAMHSA and the Lifeline, however it is worth noting that the option to press one is provided immediately to reduce the number of veterans waiting to receive help.

In the VCLs opinion, the best of these two options would be to provide a dedicated three-digit code and provide similar location-based services that 911 currently utilizes.

4. **Mnemonic Value:** Of all N11 codes (211, 311, 411, 511, 611, 711, 811, and 911), which offers the best mnemonic value to suicide and other crisis callers? In other words, which would be easiest for a person in crisis to remember when placing a call to Lifeline? Why?

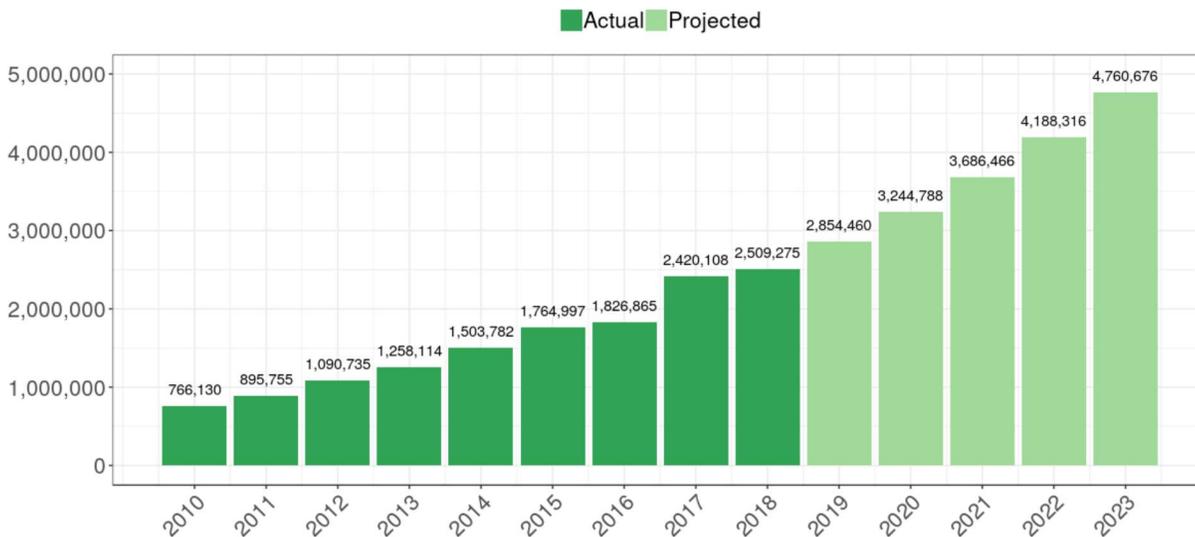
The VCL has not completed an analysis on the cognitive ability to recall a N11 code in a time of crisis. We do not have an opinion on the best mnemonic value to assign if the FCC recommends enacting a 3-digit code for crisis response.

Appendix D: April 2, 2019 Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA) Response to NAOWG N11 Inquiry

1. **Question: Projections:** The charts on page 11 reflect the most-recent historical growth in Lifeline’s overall call volumes and numbers of answered calls at about 9% (2017-2018). The growth in some earlier years exceeds that rate. Then, under Cost Considerations on page 20, it is suggested that a 100% increase in the number of crisis calls could result from the ease for crisis callers to contact an N11-based crisis resource.
 - a. Is this 100% increase entirely hypothetical?
 - b. Is it first-year only, and what levels of increase are expected thereafter?
 - c. Are there any scientifically-based projections on the growth of overall Lifeline call volumes? (If so, please provide for all years available.)
 - d. What percentage does Lifeline comprise of the total number of calls nationally to analogous crisis and suicide lines? In other words, what is the total of all calls to crisis and suicide resources such as Lifeline (including Lifeline counts as a component)?
 - e. What other empirical data can you provide that may assist us in determining the overall “market” (for lack of a better term) in the context of call volumes for the services of such crisis and suicide lines nationally on a historical and going-forward (projection) basis.
 - f. If you have any other references or resources that you believe to potentially be of value to us as we gauge projected call volumes, please share.

SAMHSA Response: The 100 percent increase referenced was not intended to be a precise estimate of call volume if an N11 number was assigned. Rather it was intended as a plausible estimate for the purposes of estimating costs for increased phone volume incorporating the historical pattern of growth in Lifeline calls (without an N11 number) combined with the expectation that an N11 number would increase call volume to at least some degree. The attached graphic contains the administrators of the National Suicide Prevention Lifeline projected growth of Lifeline volume (without factoring in an N11 number). This would estimate 4.76 million people calling the Lifeline in 2023.

Lifeline Call Volume With Projections Through 2023



Since 2010, the Lifeline has averaged an annual growth in call volume of just over 15 percent. This average increase is similar to Lifeline Crisis Centers reporting their total call volume of 13 percent between 2016-2017 and 14 percent between 2017-2018.

There is currently no definitive means of estimating the total number of crisis or suicide calls in the United States. The American Association of Suicidology estimates that there are approximately 700 crisis call centers nationwide. The Lifeline administrators surveyed the 165 Lifeline Crisis Centers regarding the proportion of all their calls that are Lifeline calls. Of the 93 Lifeline Crisis Centers who responded to the survey, 19 percent of their calls were Lifeline calls and 81 percent were calls on their local numbers for federal fiscal year 2018. Generalizing to the entire Lifeline network there are 11.5 million calls answered by Lifeline Crisis Centers. This would clearly be an underestimate given the number of crisis centers who are not part of the National Suicide Prevention Lifeline.

A relevant piece of data for understanding the potential “market” for calls to an N11 number would be the data SAMHSA collects regarding Americans age 18 and over who seriously consider suicide each year. This information is collected through the National Survey on Drug Use and Health (NSDUH). For 2017, 10.6 million American adults seriously considered suicide. This number does not include suicidal youth under the age of 18, and does not include those who might report having any suicidal ideation and would not report “seriously considering suicide.” SAMHSA would not consider it likely that 100 percent of suicidal people would call the 800-273-TALK Lifeline number or an N11 number, which is the most important target population for the National Suicide Prevention Lifeline.

The Veterans Health Administration (VHA) has also estimated potential call volume for an N11 number based on review of data and discussions with the managers of the 111 system in England. Adoption of the 111 system did lead to an increase in mental health calls. The VHA also estimated potential call volume based on an analysis of current mental health call volume to 211 in the United States. For more information on these projections, please see the VHA’s response to the NANC’s questions.

- 2. 911 Shared-Use Scenario: 911 PSAPs/call centers have access to location information, Kari’s Law access from multiline premises equipment, immediate emergency-dispatch capabilities, and call-transfer capabilities. Please describe in a few paragraphs the relative benefits of having a dedicated N11 code for crisis calling compared to benefits of having a shared infrastructure with 911 that has such capabilities. (Note that I am asking this to gain an objective understanding, and I am not suggesting that one approach is better than the other. I recognize the very-substantial investment by all entities involved in the deployment of such 911-specific capabilities, and the unlikelihood that all such capabilities could reasonably be deployed for another N11 code or for any other dialing arrangement.)**

SAMHSA response: 911 clearly has important capacities that would be of great value for the National Suicide Prevention Lifeline if there were a shared infrastructure but there are also potential drawbacks. The geolocation capacities and the immediate dispatch capacities of the 911 system would be of immense value when someone is in the process of making a suicide attempt or who is otherwise in need of emergency rescue (for example, a person who is actively suicidal, intoxicated and with a loaded gun by their side). The National Suicide Prevention Lifeline does not currently have geolocation capacity, which could be lifesaving in some instances. The Lifeline Crisis Center responder must contact local emergency services and request the dispatch of police and/or ambulance. Often this must be done while keeping the caller on the line and engaging a supervisor or colleague to make the connection. Some, but not all, Lifeline Crisis Center have services to dispatch mobile outreach. The Lifeline estimates that 2 percent of Lifeline calls currently result in emergency rescue being initiated. However, since the overwhelming majority of Lifeline callers do not fall into this category, the risk would be that 911 dispatchers who might be called upon to triage these additional 98 percent of Lifeline calls, would not have the time or training to engage the caller, create rapport, perform a suicide risk assessment, and deescalate suicidal callers to the point where emergency response is not required or appropriate. The process of warm transferring such calls from 911 to the Lifeline Crisis Center Network could be problematic and result in callers abandoning the call because of not wanting to have to speak to more than one person. There would also be a risk of an increase in Lifeline callers being sent to overburdened Emergency Rooms. In addition, 911 is firmly embedded in the public mind with first responder dispatch to the location of an emergency; so those who do not want an ambulance or police dispatched might avoid calling, as opposed to a designated N11 number other than 911 which could be branded for urgent or crisis calls but not emergency response. An alternative N11 number would not have the geolocation capacities of 911; however, less precise geolocation could potentially be explored as an alternative that might allow a caller using a cell phone to be routed to a Lifeline Crisis Center in the closest county who would have knowledge of local community resources and emergency response systems. Currently, these calls go to the area code of the phone rather

than the physical location of the person. Additionally, public education efforts to inform the public that a person thinking about suicide should call the Suicide Lifeline N11 number; and if a person is attempting suicide, 911 should be called, could be helpful.

- 3. Mnemonic Value: Of all N11 codes (211, 311, 411, 511, 611, 711, 811, and 911), which offers the best mnemonic value to suicide and other crisis callers? In other words, which would be easiest for a person in crisis to remember when placing a call to Lifeline? Why?**

SAMHSA does not have information regarding the superiority of any particular N11 code regarding ease of recollection during a crisis. The only relevant data that SAMHSA is aware of comes from the lab of Dr. Thomas Joiner at Florida State University. While Dr. Joiner compared a 3-digit N11 number to a 3-digit control (non-N11) to the Lifeline's 800-273-TALK it did not include a comparison among N11 numbers.

Appendix E: March 2019 AIRS Survey of Blended Information and Referral/Crisis Members

Crisis, I&R, N-1-1s and IVRs: AIRS Survey of Blended I&R/Crisis Members March 2019

Q1. Does your organization operate a crisis service?

Yes	100%	37
No (This excuses you from the remainder of the survey!)	0%	0
	Answered	37

Q2. Does your organization operate a service that specializes in crisis intervention/suicide prevention?

Yes	92%	34
No	8%	3
	Answered	37

Q3. Is your organization part of the National Suicide Prevention Lifeline?

Yes	76%	28
No	24%	9
	Answered	37

Q4. If you are part of the NSPL, do you operate/promote a regional or statewide crisis program with its own separate phone number?

Yes	55%	18
No	45%	15
	Answered	33

Q5. Do you consider yourself a "blended" center (i.e. providing both I&R and crisis services) even if they are operated separately?

Yes	100%	37
No	0%	0
	Answered	37

Q6. In addition to operating a crisis service, is your organization part of the 2-1-1 network?

Yes	100%	37
No	0%	0
	Answered	37

Q7. If you are blended, which of the following best describes the relationship between the crisis and I&R programs? (The reference to "interchangeably" means that although to the public both services may be separate, internally, the same staff may answer either line).

They operate independently with professional staff handling both lines	6%	2
They operate independently with volunteer staff handling both lines	0%	0
They operate independently with volunteer staff handling the crisis line and professional staff handling the I&R line	6%	2
They operate independently with volunteer staff handling the I&R line and professional staff handling the crisis line	0%	0
They operate interchangeably with professional staff handling both lines	74%	25
They operate interchangeably with volunteer staff handling both lines	15%	5
	Answered	34

Q8. Does your crisis line provide service in chat and/or text?

We offer both chat and text	26%	9
We offer chat in addition to a phone service	12%	4
We offer text in addition to a phone service	29%	10
We plan to offer chat and/or text within the next 12 months	32%	11
	Answered	34

Q9. Does your crisis service open with a voice message or are all calls answered by a live person?

There is a voice message	65%	24
The first thing a client hears is a human voice answering their call	35%	13
	Answered	37

Q10. Does your crisis service contain an IVR message of any type? (e.g., press 2 for Spanish or press 1 to reach a veteran)

Yes	65%	24
No	35%	13
	Answered	37

Q11. If so, what type of message?

Crisis, Language, a couple specific programs
English/Spanish option. Then, crisis/211/homeless services option.
I wasn't sure if I should have answered 'yes' or 'no' to this question. We don't have an IVR for crisis calls, but the NSPL does. When people call the NSPL, they hear an automated message asking them press an option for English or Spanish. Based on their area code, calls are then directed to our center, and are answered directly by one of our navigators.
If you are suicidal or experiencing a mental health emergency, please press *.
If you dial 2-1-1, there is a message that if you are in need of crisis intervention, press 1. If you dial the NSPL number or any of our other crisis lines, they are live answered.
If you would like to speak to a counselor press 2
Press # to speak to a volunteer or staff.
Press 1 for crisis 2 for information and referral
Press 1 for Veteran
Press 2 for Spanish, connect to nearest crisis center or press 1 to speak to veterans crisis line.
Press 8 to reach a Helpline Specialist.
Press one to speak with someone now
recorded
"Select Language: English, Spanish, Mandarin/Cantonese
Select: Peer Support Specialist or Counselor"
Something along the lines of "Thank you for calling, press 2 for Spanish (in Spanish), press 3 if you are in a crisis, press 4 for all other questions"
Thank you for calling the [211 Center]. To speak with one of our staff about information and referrals, crisis assistance or other assistance, please press 2.
Thank you for calling the [Line], for assistance in Spanish push 2, for assistance in English press 1. Then additional options are available.
The crisis-specific IVR informs the caller that the line is staffed 24 hours, to dial 911 for medical emergencies, how to access our confidentiality policy & to press 1 to connect to a specialist. On our 2-1-1 line, the same initial info is presented, with "press 1 if you are suicidal or experiencing a mental health, personal or family crisis".
The message gives identified veterans an option to speak with the Veterans Crisis Helpline.
There is an IVR for veteran staff, to choose crisis or i&r, and to choose some of the other programs we operate including Child [Line]
to speak with a call specialist about a substance abuse or mental health problem, press 1
We have options for language and for crisis services

We switched to IVR relatively recently, the end of January 2019. Our message contains English and Spanish with prompts to speak directly to our crisis line in addition to hearing about our services. Our IRL is separate and does not use IVR.

You have reached 211 [Program] Please press 1 to speak with a counselor

Q12. If you use an IVR message, do you believe it has a:

negative impact.	4%	1
positive impact.	52%	13
makes no discernible difference.	44%	11
	Answered	25

Q13. Please describe the reasoning behind your previous answer.

Allows more accurate and expedited routing. Provides immediate choice to the individual.
I don't believe it makes a discernible difference because we have not received any feedback from our community that it does have a negative impact. The calls keep coming in and we provide the best possible service to our community.
it allows for an effortless experience to the caller
It avoids 211 phantom calls being routed to the counselors
It has pros and cons. Pros: language selection, screens solicitor and phantom calls. Cons: can be hard to follow for someone in crisis or have language/cognitive barriers.
It has the effect of letting people know that there is someone there for them but also has given us the ability to screen out a number of robo call messages and people who have dialed the number incorrectly
It is still too early to tell; however, our IVR has cut down on prank and wrong number calls.
It makes things clear with getting the client to the right place.
Our message of giving veterans an avenue to connect with service members who can relate to a crisis proves it's positive by the number of inquirers that select the option.
People choose whatever they want and it doesn't matter to us really. This is a requirement of a different line and not one that internally we would have chosen to implement. Our voice was not heard on this point.
People in crisis or who are suicidal need to have human contact asap so that they feel valued.
Positive for us because it can properly direct calls to the appropriate scripting so that call agents can answer each line appropriately for the identified services. Also, it eliminates call time as some of the demographic information is integrated from our phone system to our database which saves time/money. However, I believe that it continues to be frustrating for some callers who don't want to go through the process of pushing prompts or who are in the middle of a crisis situation.
Positive, because it allows us to efficiently route calls to the most appropriate Specialist & because it allows us to prioritize crisis calls.
The alternative is a ringing phone number with no one picking up until an agent is available.
There has been no increase in abandoned calls since adding the message and there are no complaints about using it.
We find it very important to prioritize crisis calls. The IVR has greatly allowed that to happen. Most people use the crisis option appropriately. Of course not always.
We only recently implement this IVR feature, so have yet to determine it's impact.
We were getting dozens of phantom calls daily until we added the IVR message.
We've had this in place for around 20 years and receive minimal negative feedback. Callers wait or leave messages as they do for I&R calls.

Q14. If you have been following the discussions about using an N-1-1 number for suicide prevention, which do you believe is the BEST option?

Share the 211 number while ensuring that suicide prevention calls continue to only be answered by trained crisis workers	58%	18
--	-----	----

Use 311	3%	1
Use 411	0%	0
Use 511	0%	0
Use 611	6%	2
Use 711	0%	0
Use 811	10%	3
Share the 911 number while ensuring that suicide prevention calls continue to only be answered by trained crisis workers	3%	1
A three-digit number is not needed	19%	6
	Answered	31

Q15. Please fully describe the reasons behind your previous answer.

<p>2-1-1 is a natural fit to be blended centers. 2-1-1 should be open to this innovative change. With appropriate training, 2-1-1 centers may find they are managing more crisis calls than they think. AIRS standards have offered 2-1-1 Specialists the foundation to provide crisis services. The 2-1-1 network has the capacity to manage these calls. They have the technology and infrastructure. Customers would easily connect the 3 digit number to both I&R and crisis.</p>
<p>211 is already promoted in many communities and areas of the country for crisis. 211 will continue to get these types of calls regardless. People in crisis and their families often need help with other things, and it offers a simple option to address the immediate crisis and over time to follow up and address other needs. 211 handles behavioral health issues now, many of which are synonymous with crisis/suicide issues - substance abuse, anxiety, depression, bullying, support for mass casualties, etc. To begin to parse calling "xxx for this" and "211 for that" and "911 for the other" is confusing and doesn't make sense. The idea is to make it simple. It may be more cost effective to raise the standards and skills for existing 211 providers and ensure that they all provide crisis services than to create another nationwide infrastructure to support what many 211s already do. We have an opportunity to establish 211 as the health/human service/crisis number and to make it as well known across the country as 911 is for emergencies. Communities already invest heavily in 211. If they were called upon to help support a different number for crisis/behavioral health, the result would likely be a weakening of the 211 system or a lack of support for an additional crisis number. 211s have knowledge of local services and systems and relationships with people they can call, they can describe in detail exactly what services there are, how they operate, and what a caller can expect. That can make the difference in whether a caller chooses to access those services. Follow up is an essential part of the service 211s deliver to crisis callers. It's not just the incoming call and the immediate crisis but keeping people safe over time. I haven't heard this as part of the discussion.</p>
<p>211 is already the nationwide number designated as the "First call for Help" Helpline. It makes sense to expand a number already being used to access services. Many are already crisis lines as well. To many N11 numbers, being used for different purposes, are bound to create confusion (and avoiding confusion and expediting help are the reasons we created N11 numbers in the first place)</p>
<p>211 is no equipped to handle crisis calls. The volume of calls on 211 and Crisis in my organization are similar- we would not want s call about rent assistance to be bumped ahead of a potentially life threatening crisis call</p>
<p>800-273-TALK is more widely recognized than 2-1-1. We have found that 9-1-1's are too burdened to take on crisis counseling. In fact, we have actually trained the 9-1-1 staff on how to handle suicidal callers while help is on the way. They were very uncomfortable with being on the phone with these folks, not knowing what to say. As far as another N-1-1 number, it would take 30 years for it to become a household number.</p>
<p>811 is closer to 911 than any other 3 digit.</p>
<p>911 would be more for suicide intervention (vs. prevention) and all of the other N-1-1 services are a bit out of scope. 2-1-1 is the only one that makes sense in terms of connecting people to the various resources they may need.</p>

All of our staff are trained in an evidence based model for crisis intervention which serves as the basis for our approach in working with callers whether they are in need of I&R or crisis services. We have had 2-1-1 engrained into the crisis/behavioral health services for our service area, and have been met with success. It is an easy number for not only the public, but other professionals to remember.
As an NWPL partner, only 15 calls a month on average are active suicides. The remaining 175 plus calls are for telephone reassurance with some needing a safety planning. From our perspective, there is not enough true lethal crisis to have the partnership be with 911.
As so many 211s are trained and ready to provide the service it seems counterproductive to have another separate three digit number. And hopefully 211 is widely recognized, and we could use any additional resources meant for publicity to continue to promote 211 as opposed to a separate number.
Based on the 211 network in our state, I would not recommend using the 211 dialing code for NSPL calls at this time. Callers will have to navigate through too many options to get help.
Because many 211 services are also crisis intervention hotlines (and many are also Lifeline providers), it would be confusing and multiplicative to have two different 3-digit numbers. In Florida, more than 50% of the 211 services are also crisis and 9 of the 13 2-1-1s in FL also answer Lifeline.
Do we really need another N11? It's been hard enough getting public understanding of 211. Make use of the network.
either 3 digit number allows for a quick dial and easy to remember
I can't choose just one of these. Our staff is cross trained at this point and answer both calls. This is manageable for our center at this time.
I see benefit in a N-1-1 number but am not following which number is most appropriate. a 3 digit number will help to promote suicide prevention on a national scale and better connect individuals to the level of care / intervention / support while reducing high cost resources such as 911 where it is not warranted.
I think 211 would work with a routing system in place.
In our blended center, we are 50/50 on either side of the fence. We have crisis calls that come in on 211 and are readily available to meet the need as if the call came from dialing the NSPL 800 number.
in some cases the 211 caller is in crisis and even if the immediate need is met we in find in talking to them that their life is in crisis and any single event can result in suicidal thoughts or ideation
In todays world of instant access to the internet, a person who is suicidal will reach out if somewhere in their mind they are not sure if they want to go through with it. The ones that make up their mind to commit suicide 9 out of 10 times will not call anyone. (talked to 100's over the last 30 years)
Locally for us 611, 711, and 811 are available. The first five are in use.
Often, 211 calls are crisis calls. It's good to have trained workers know how to work with both.
Our mission is to promote the health and well-being of all people in [state] through a statewide information and referral service for STREAMLINED ACCESS to community resources.
the community is already aware of the NSPL number
The money that would be necessary to add and promote another three-digit number is not worth it. The money should be used to support the agencies doing this work which are under paid.
We answer the phone 8 different ways depending on the line it comes in on. This gives us a chance to "get our head in the correct framework" for the expected type of call. 2-1-1: we know it is primarily Information and Referral, the NSPL line: chances are it may be "critical" with possible immediate outside response. Much different impact on the call-taker.
We currently provide both services and all staff are trained with this aspect of things vs the other N11 lines. A new number may help with funding opportunities as there are funders more focused towards I & R and others more towards suicide prevention. The number 111 could be another option to consider since it's not currently in use from my understanding.
We were a NSPL. Not only does the NSPL not offer enough support to the individual centers who ARE a NSPL, it will only further confuse callers who are trying to reach them and I&R Services. Some of us use 211 for Disasters and need to move Disaster related information to the front of the IVR for the

duration of the event. What would happen to the NSPL then? Too much information on the IVR confuses people, especially those in crisis. It is also my experience, having been a NSPL and 211, those who call the NSPL have the option to speak to a veteran. MANY of them push the wrong prompt and are furious when they are not directed to the Veteran Lifeline that they were trying to reach. If we forwarded the calls to the appropriate Veteran component, we were often chastised for doing so, OR other issues came forward. HMIS has already burdened our system (database) and use of the 211 number, adding the NSPL will only create additional issues. Plus, is there anticipated dollars to follow their desire to utilize our system? Some states (like mine) use inContact and we are billed for certain things. Until we are all on a national platform phone system wide, I feel that it is a burden that will be felt at the state/local level for 211's.

We were blended before and since becoming a 2-1-1 in 2001 & it has worked. Opportunity to pool existing resources and maybe see some national dollars supporting more direct service delivery if less is required for telephony infrastructure.

We've already moved to using 211 as the singular number to access all of our services, including crisis/suicide prevention, 211 I&R, and our grief counseling program. We have received nearly universal praise for this move, as it has greatly simplified access.

Q16. If you have been following the discussions about using an N-1-1 number for suicide prevention, which do you believe is the MOST REALISTIC option?

Share the 211 number while ensuring that suicide prevention calls continue to only be answered by trained crisis workers	61%	19
Use 311	6%	2
Use 411	0%	0
Use 511	0%	0
Use 611	3%	1
Use 711	0%	0
Use 811	10%	3
Share the 911 number while ensuring that suicide prevention calls continue to only be answered by trained crisis workers	3%	1
A three-digit number is not needed	16%	5
	Answered	31

Q17. Please fully describe the reasons behind your previous answer.

211 is already being used and it there wouldn't have to be a significant shift in scope (switching to 411 would not be intuitive, for example, & 611 has other designations)
All of our 211 and Lifeline calls are answered by the same group of counselors (both professional and volunteer). If a 211 service does not currently provide crisis hotline services, they could use an IVR/autoattendant to route the crisis/suicide prevention caller to a crisis line; or they could train their staff to provide that service.
All other N-1-1 numbers are already in use by either other government entities or utility companies. 9-1-1 operators are not equipped to meet the needs of individuals in crisis. 2-1-1 is the only N-1-1 service which would be able to adequately adapt to working with individuals in crisis in addition to its current function.
Continue using an easy number that is already being utilized in communities. Changes in services, numbers can also cause additional trauma to those seeking services.
either 3 digit number allows for a quick dial and easy to remember
I dont believe any of the N11s should lose their status. 211 seems like the likely candidate for crisis intervention/suicide calls.
I don't think we need a 3 digit number but if it's going to change, it should be something that isn't already used, and should be merged with another service such as 911, 211, 311
If those suicide calls are answered by a live person and not like some centers who give you a menu when you call

In our blended center, we are 50/50 on either side of the fence. We have crisis calls that come in on 211 and are readily available to meet the need as if the call came from dialing the NSPL 800 number.
In our community, we have been a blended crisis center for over 24 years. The [County] community values 2-1-1 as a blended center. People in the community are not confused by the fact that 2-1-1 is a blended center. Meaning the community has not demanded or looked for our Center to have distinct numbers for each service. The argument that the community needs a distinct number for crisis is not validated by the [County] Community. As a matter of fact, almost all 2-1-1 in the state of the Florida are blended centers. The State of Florida shows that 2-1-1 can be promoted in the community as blended centers. The fact is many people call 2-1-1 first to resolve basic needs and while conducting safety assessments are identified as being in crisis as well. Yes, it requires 2-1-1 to enhance its level of service. It will require staff to be competent in managing blended calls. 2-1-1 has a track record of being innovative. It has launched text and chats services. Has standards that mirrors much of the crisis accreditation services. As a matter of fact, [2-1-1 County] found conducting the AIRS accreditation at the same time as the American Association of Suicidology was very helpful because much of the work is mirrored and helps complete each other's requirements.
Locally for us the first five are in use. The numbers 611, 711, and 811 are available.
More cost efficient to build on existing infrastructure and awareness than start something from the ground up.
Most realistic would be this or a completely new N11 number such as 111
professional trained staff is essential in both cases -- we cross train our staff
See above. The infrastructure is already in place for our 2-1-1. And AIRS dictates that all 2-1-1 have a partnership with a crisis service.
Streamline access
The National numbers are widely publisized and utilized. Much less likely to have a prankster call than a simple 3-digit number.
The reasons above, and the infrastructure is already in place to build upon. UWW and AIRS (in partnership with NSPL) can provide national leadership in helping all 211s to transition to blended services and can oversee the process. UWW has staff dedicated to expanding 211 and is well positioned to lead national fund raising efforts to help support 211 crisis services.
The volume nationally doesn't rise to the level of needing its own N11 number. With additional funding, the 211 network could absorb the calls.
There are already so many 3 digit numbers in use that it continues to confuse many callers. Which number is 411 for? What is 211 for? We will undoubtedly get calls for people trying to reach the NSPL (by dialing 211) because they can't remember which 3-digit number has been assigned, or because they just don't know. NSPL has done a great job marketing their current number.
Training and implementation would be easier on some levels, but also very challenging for some.
We are already using 211 with great success. It works.

Q18. If the current NSPL operation could use the three-digit 211 number while maintaining its distinct expertise (e.g. suicide calls only answered by NSPL approved staff), what might be some of the advantages or disadvantages? (Note that this could mean two totally independent uses diverging from the same number or else some levels of integration)

2-1-1 could get people in crisis connected to help quicker
Advantage: Shared funding, shared marketing, and more professional development training for agents. Disadvantages: Fight for power and control of the 211 brand. United Way 211's that are not involved in crisis work may be reluctant to take on this business.
Advantages - The most important reason - let's have a client-centered approach to offer people support. Having more and more distinct ten digit or even 3 digit numbers only makes it harder for consumers. Many 2-1-1 have shown how effective they can be as blended centers. Look at what 2-1-1 [examples of specific services] have accomplished. All these centers could have distinct expertise even though technically staff can and are trained to offer both I&R and crisis. The advantage if you are fully

funded to offer crisis services, you can focus on offering a comprehensive crisis program that includes ongoing follow-up with people in crisis.
Advantages as noted in #17. All of our staff are trained to NSPL/AAS and AIRS standards, so we know this can be done. In the case of any change in #, NSPL loses the awareness of the existing # & potentially creates some confusion - but makes more sense to me to expand notion of 2-1-1 (which in many areas is already known for both) than re-brand other 3-digit #s.
Advantages would be an easy to remember number to get connected and place 211 on a national platform comparable to 911. Some of the disadvantages could be some confusion between I&R and Suicide prevention even though they can overlap.
Advantages: it could divert non-crisis/suicide related calls from NSPL. A simple number to remember for service users. 211 worker skills related to crisis/suicide would be enhanced. Service users would get other appropriate referrals. Disadvantages: an increase of crisis/suicide calls to 2-1-1. If 2-1-1 is advertised as being used for suicide prevention, then some of the challenges NSPL faces re: service users inappropriately using the serve would also translate to 2-1-1, which could be a drain on resources.
Advantages= allows for a quick dial and easy to remember. Disadvantages= Internal confusion of the gravity of the call
easier number to remember and quicker support for those in need
Easy to remember number that can integrate all services. Our model is that all call specialists; staff and volunteers, are cross trained to answer both crisis and I&R calls. You could then triage to those with more expertise in certain areas, if you wish.
I'd like to see NSPL continue to oversee the entities answering that number to ensure crisis counselors meet certain training/ qualifications standards. This has obvious benefits. Using the 211 number has numerous benefits, itemized above (# already in use, already designated as the first call for help, easy to remember, less confusion, etc)
If NSPL does massive promotion of 211 as suicide only calls, it could dilute our image as a more full service 211. I don't think we should lose the part of 211 that offers I&R
I'm concerned about a caller in crisis having to choose among several options when they call 211.
It will mean more centers participating in the NSPL network providing better and more adequate coverage nationally. It will mean more publicity of 2-1-1. It will allow for individual call centers to leverage funds from a more diverse stream. One potential headache would be centers having to merge or close if both a crisis hotline and 2-1-1 provider exist in a community.
Less confusion for the public. Call one number to get what I need vs knowing the 'right' number
Not sure how to respond to this question. I don't know if its feasible or cost effective to route all local 211 calls to the NSPL central hub to be rerouted back to the local 211 that is also a crisis line. However, I'd be open for discussion about how to make this an effective system.
Our Crisis line is required by NCQA standards to be live answered within 30 seconds 95% of the time. There is not enough 211 or Crisis funding to handle double the volume of calls with a live answer within 30 seconds in our community. Potentially suicidal callers don't want to navigate a complex phone tree- they want and need a supportive person to help them at the time they call.
Our staff is cross-trained so I don't think it would present a problem.
Pros: Could utilizing existing infrastructure. Cons: How would suicide calls be identified? What would the public perception be of combining a support service with a known I&R only service? Would they hold concerns that they are only going to be referred somewhere? What would the impact of this be on contacts outside of business hours.
See response above. I do not see any advantages. I base this on 15 years of experience in the field, being an I&R that is also a small Crisis Center, and having been a NSPL provider for 3 years for our state.
Small crisis centers would have a problem with finding someone who is NSPL approved or trained.
Budgets constraints
Streamlined access to help

The number would be easily recognizable and we have found that dialing three digits is easier and people will be more likely to use it rather than the 10-digit. The disadvantage could be confusion among the community about its use.
The same response I gave to Question 15.
We currently promote 211 locally for crisis and non-crisis (population base 2 million) and also answer the NSPL number. As a result, 211 is called upon locally by community leaders, government, business, etc. for a variety of help related to suicide - the obvious as well as trainings, support for a recent mass casualty, promotion by schools to students/parents, help answering a short term crisis line, easy number to promote for local information and support. A huge advantage is the ability to talk with callers in detail about the services and systems that are in place locally and knowing (because you're in planning meetings) how those services have been adjusted to meet the needs of the community after some type of incident. I also cannot overstate the importance of giving one simple number for everything. People who are thinking about suicide or care about someone who might be are already stressed and in a highly emotional state. They don't need to have to figure out what number to call for what. There are too many gray areas when it comes to behavioral health/suicide and trying to discern the difference between numbers.
We have InContact with the ability to route the calls to operators who are trained in answering suicide calls. Right now all operators are trained in suicide assessment so it would be a moot point. However, it is an option for the future.

Q19. What type of IVR might be either a realistic or helpful part of a 3 digit suicide prevention line?

1) Develop a singular IVR best practice strategy for all 211's to adopt.
2) Develop a single IVR for the nation with calls passing live to centers based on area code or zip code like the texting platform.
3) Develop a single system like 911 that allows for all media to pass through the IVR and queue for agents (calls, chat, texting, emails).
English/Spanish, immediate physical danger
Even with the best IVR, Crisis calls would end up going to I&R staff, hence any shared use of the 211 number you would have to make sure all staff are properly trained.
For language
I do not agree with assigning a 3 digit number for Suicide Prevention.
If I was suicidal I cant think of any three digit number that would make me want to call. Again instant access to the internet
Language option, crisis vs. I&R option.
NICE-inContact is way we currently use
None that I am aware of
None- other than the veteran option
Not a fan really. People will select based on what they think (e.g., If I press 1 I go to the head of the line) and may not be true at all. It's important that whoever answers the phone can handle whatever they answer.
One that could designate a client to select if they are calling due to suicide or are they calling for community resources/general counseling.
One that does not require the caller to respond to several options before getting help. I think the only options I would include would be "English or Spanish" and zip code. Right now, NSPL routes calls based on area code, and this results in us receiving many out-of-area callers who have a cell phone number that they first got in our state. It's sometimes difficult for us to find resources in other states.
press # to hear terms of service, press # if you are looking for specific information and resources, press # if you are in crisis and want to speak to a trained crisis worker. If this is an emergency, please press # to be connected to 911.
Press 1 for information and referral and 2 for crisis support
Routing (ie specific languages, population) not triage.

We have never used an IVR, and are opposed to the idea. However, we have considered a "mini" greeting to offset phantom calls.
We pride ourself in having a live person answering each call within 6 rings.
You could have callers press 2 for crisis and 3 for all other calls. Not sure you would want multiple options for a suicide intervention service. Speed and quick connection is preferred.

Q20. How might you avoid possible routing issues about English/Spanish, immediate physical danger, veteran or other special population status, geographic location, etc., without IVR use?

Answer each call as an emergency.
I don't think it's realistic not to use an IVR. NSPL uses an IVR at the front of the current system to route to local centers, though Lifeline prefers we not use an *additional* IVR.
I don't think you can.
I think that would be impossible to avoid routing issues.
In our opinion, IVR is effective for language option, but less so for other options. Consumers will press any number that they think will get to someone faster.
Not sure other than an initial evaluation from a counselor.
not sure other than specialist gaining information from the caller
Not sure. IVRs are very helpful for this. Perhaps funding needs to be provided to ensure all the core providers have IVR, or perhaps calls are routed through a neighboring 211 IVR system and programmed to forward to the partner who doesn't have an IVR, or staff have to be sufficiently available to manage the call volume & needs.
NSPL uses an IVR prior to routing to local crisis centers. I would use what is already in place. NSPL currently uses a system which routes callers to the closest crisis center with minimal wait. However, it has happened from time to time that the caller is routed to another state or even across the country.
Physical danger should use suicide options to prioritize the call. Routing for special populations should be done via separate IVR trees. The IVR should not be specialty population driven, but need driven.
We currently do not use IVR for any of those areas. For example, if the inquirer wants another language, they request it and we set up the tele-interpreter service.
We manage this with a live call screener who supports the person within 30 seconds
You can't avoid routing issues even WITH use of an IVR. See comments above.
You would have to train staff on internal protocols on each possible issue such as language barriers would use tele interpreter service.

Q21. Please share any additional thoughts you want to share on any of the issues covered in this survey.

Difficult choices to make. I think the same way that there are reasons behind having 311, 211, and 911 is the same reason why there should be something specific for mental health and suicide concerns. But, I think 211 centers could also benefit from the opportunity with operating a new N11 line focused on this.
I am new to the NSPL N-1-1 conversation; however, I look forward to hearing more. Also, as a follow up to question #5., we use professional staff and volunteers to answer our crisis line and only professional staff to answer our IRL.
It really comes down to having enough call specialists, so people aren't waiting, and the funding to support this. In our eyes, a single woman with kids, leaving on the street, and without food, is in a crisis, and our staff and volunteers are trained to respond to their needs, both physical and emotional.
It will be important to know the guidelines for providing Behavioral Health Hotline Services in each state. For example, only certain professional licensures may supervise a Certified Behavioral Health Hotline in Ohio. On a different note, I truly believe 2-1-1 and NSPL can easily be integrated from the perspective of service delivery.
NSPL only provides a partner \$1500 annually to answer calls. This is not enough to cover expenses for calls or staffing. If NSPL wants to parter with 211, they need to provide direct funding to cover

expenses. If not, 211 brand should not be tied to the NSPL brand and all 211's should cancel their contracts.
Question 7- none of these were completely accurate based on my understanding of the question. We use both volunteers and paid staff to answer all the lines in our call center. If you answer the phones, you answer everything.
Routing needs to be done by zip code, not only by area code.
The National Suicide Prevention Lifeline is a WONDERFUL service. I am a huge supporter and encourager of what they do, and how many lives they are saving on a daily/annual basis. However, there has been disconnect between management and where the "rubber meets the road" with centers that provide the Lifeline services oftentimes. They give an annual stipend of \$1,500 to each participating agency to take their calls, regardless of call volume. Last year, we fielded almost 8,000 from my shop for our state on a \$1,500 stipend. This means that it cost my agency money to have adequate staffing available for the length and nature of these calls. It came to the point where it just wasn't feasible. Unless you are housed within a state run Mental Health/Crisis Center I honestly don't know how anyone can afford to take the calls. The fact that the NSPL thinks it is okay to only give those who are doing the hard lifting, such a small amount tells me a lot about where their concerns truly are as an agency. Disheartening and I don't share that publicly as I am also trained as a National Suicide Prevention ASIST Trainer. However, I don't see why we would want to partner with them. Like minded causes (for some of us) do not always make the best partnerships. Seems upside down, but that is the truth of my realistic experience.
The population is changing and the younger generation sees talking to someone has something they don't want to do. why do you think they text instead of calling. We are becoming anti social with no actual interaction with others.
The reality is 2-1-1 already manages a high volume of crisis calls. Many reasons why people go into crisis are what people call 2-1-1 for help. People call 2-1-1 due to losing a job, housing, low-income stressors, legal entanglements, seeking mental health treatments, uninsured. etc. No other network of providers can compete with the 2-1-1 comprehensive resource databases to link people in crisis with services. The 2-1-1 is a natural fit as a crisis intervention center. Funders often talk about avoiding duplication of services, finding efficiencies, and collaborations. 2-1-1 infrastructure helps accomplish these important goals.
Thought provoking. The 211 (and 3-digit numbers in general) routing system should be addressed by the Federal Government and they should mandate that all phone providers/systems provide free and reliable connections to a 211 service. We continue to have callers say the 211 number did not work so they called our 10 digit number.
why isnt there a "111" and why couldnt that be used?

Q22. (This response will be hidden from any public display of the information). If the opportunity arose, would you be OK being contacted for further information and/or to participate in a discussion? If so, just write your email below ... and it won't go anywhere without your permission.

20 respondents affirmed their willingness to be contacted and/or participate.